DEPARTMENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED
CENTERS FOR MEDICARE	& MEDICAID SERVICES	-		O	MB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				`́сом	E SURVEY IPLETED
	345229	B. WING				C 30/2015
NAME OF PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RESOURCES - SHELB	Y			101 NORTH MORGAN STREET SHELBY, NC 28150		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
SS=DBEFORE TRANSFBefore a facility trai resident, the facility if known, a family n of the resident of th the reasons for the language and many the reasons in the r include in the notice paragraph (a)(6) of Except as specified (8) of this section, the discharge required section must be mady days before the resident of the resident aunder (a)(2)(iv) of the health improves su immediate transfer (a)(2)(i) of this section; or a reside facility for 30 days.The written notice a this section must im or discharge; the loca transferred or discharge; the loca 	nsfers or discharges a y must notify the resident and, nember or legal representative he transfer or discharge and move in writing and in a ner they understand; record resident's clinical record; and the items described in this section. d in paragraph (a)(5)(ii) and (a) the notice of transfer or under paragraph (a)(4) of this ade by the facility at least 30 sident is transferred or de as soon as practicable lischarge when the health of icility would be endangered his section; the resident's fficiently to allow a more or discharge, under paragraph ion; an immediate transfer or ed by the resident's urgent der paragraph (a)(2)(ii) of this int has not resided in the specified in paragraph (a)(4) of icilude the reason for transfer ffective date of transfer or tion to which the resident is harged; a statement that the th to appeal the action to the	F2	203			8/18/15
of the State long te	ddress and telephone number rm care ombudsman; for DER/SUPPLIER REPRESENTATIVE'S SIGF			TITLE		(X6) DATE

Electronically Signed

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.

08/18/2015

PRINTED: 09/18/2015

CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345229		S 5	E CONSTRUCTION (X3) DAT COM	: 09/18/2015 APPROVED . 0938-0391 E SURVEY IPLETED C 30/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 203	disabilities, the mail number of the agen protection and advo disabled individuals the Developmental of Rights Act; and for who are mentally ill telephone number of the protection and a individuals establish Advocacy for Menta This REQUIREMEN by: Based on record re facility failed to issu one of one sampled discharge. Findings included: Resident #171 was 5/11/2015. The actif Coordination, Hype Accident and Anxie A review of the Mini 5/18/2015 revealed cognitively intact an assistance for bed in no hearing deficit; v needs; had behavio period; that included directed toward other A review of a progre	A dents with developmental ling address and telephone acy responsible for the bocacy of developmentally established under Part C of Disabilities Assistance and Bill or nursing facility residents , the mailing address and of the agency responsible for advocacy of mentally ill ned under the Protection and ally III Individuals Act. NT is not met as evidenced eview and staff interview the e a 30 day discharge notice to d resident(#171)reviewed for tension, Cerebrovascular ty Disorder. mum Data Set dated Resident #171 was id required extensive mobility and transfer. He had was able to communicate his ors during the 7 day look back d verbal behavior symptoms	F 2	203	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that the alleged deficiencies did, in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the requirements and to provide high quality care. 1. Resident #171 no longer resides at the facility. 2. For those with potential: A) An audit tool was developed on 08/13/2015, which addresses the discharge process. This tool includes, but is not limited to; Notice of transfer/discharge in writing, location being transferred/discharged to, the right to appeal, etc. B) All resident discharged in the last 60 days were reviewed/audited for compliance with appropriate discharge procedures. This has been accomplished by the Director of Nursing, Staff Development Coordinator, and the Clinica	

Facility ID: 923377

If continuation sheet Page 2 of 11

CENTEF STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			FORM A MB NO. (X3) DATE	09/18/2015 APPROVED 0938-0391 SURVEY PLETED
	CORRECTION					C	>
		345229	B. WING			07/3	80/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RE	SOURCES - SHELBY	1			101 NORTH MORGAN STREET HELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 203	(SSD) he did not fe felt like he was a fa much help. The SS Resident #171 refus episodes of yelling a helped him despite often. Resident #17 staff, bang his call I for attention. During Resident #171 in th SSD included in he interview with the ref family, the SSD end cooperative with the regain some of his A review of Social S 5/19/2015 revealed been set. A review of Social S 5/21/2015 at 12:49p 5/22/2015 at 12:53f #171 was discharge The SSD wrote in h explained to the RF Resident #171 was in therapy. Residen demanded to go ho The family reported come and get Resid transportation home for Resident #171. I his personal wheeld be transferred. All o reviewed and media (responsible party)	e Social Service Director el depressed or anxious but ilure because he needed so D noted that on 5/15/2015, sed therapy, had multiple at staff and stating that no one staff answering his call light 1 got irritated, yelled out at ight and remote on the table g an interview with the e presence of the family. The r progress note that during an esident, in the presence of the couraged the resident to be erapy and staff so that he may	F 2	203	 Care Coordinator. Systemic Changes: A) An in-service will be completed 08/19/2015 for staff members who are involved in the discharge process. It those staff members who are on a le of absences or who are otherwise of the facility, the in-service will be completed prior to returning to their assignment. B) All transfers/discharges are disc daily in the Administrative meeting a weekly with the therapy manager or designee. Any changes in planned transfers/discharges will be communicated with the appropriate interdisciplinary involvement as they occur. Monitoring for future compliance A) Will be done by auditing discharwith the newly developed tool as foll 100% of all residents transferred/discharged will be review for four weeks, 50% of all residents transferred/discharged will be review for four weeks. B) Ongoing audits will be determine the results of the prior audits. Completion of audits will be November 6, 2015. Results of the a will be reviewed at the monthly QAF meeting and weekly in the Administrative audits. 	are For eave but of cussed and cussed and ents wed ents wed ents wed ents wed ents wed ents wed ents wed and ents wed	

Facility ID: 923377

If continuation sheet Page 3 of 11

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	09/18/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345229	B. WING				C 30/2015
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RE	SOURCES - SHELBY	, ,			1101 NORTH MORGAN STREET SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
	5/21/2015 at 2:29pr will be discharged h refused to get out o verbally aggressive staff. Referral made Resident #171. SSE make follow up app office was closed." During an interview 2:00pm she reveale s family and informed had been refusing p needed to be dischar informed Resident a discharged on 5/22 SSD that he would (5/21/2015). The SS followed the policy f #171 because Resi short term. On 7/30/2015 at 2:3 therapy department was not discharged therapy department #171 's discharge a appointment. During an interview (DON) on 7/30/2019 expectation would be the facility discharge	sident #171. Services Progress Note dated m revealed that Resident #171 nome today. Resident #171 f bed for therapy, yelling, , physically aggressive with e for Home Health to follow D wrote "SSD attempted to ointment but the physician with the SSD on 7/30/2015 at ed she called Resident # 171 ' ed them that Resident #171 ohysical therapy and that he arged. The SSD indicated she #171's family that he could be /2015. The family informed the	F	203			

If continuation sheet Page 4 of 11

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION (>	(3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPLETED
		345229	B. WING		C 07/30/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/00/2010
PEAK RE	ESOURCES - SHELBY	(1101 NORTH MORGAN STREET SHELBY, NC 28150	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' 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)	DATE
F 203	Continued From pa	ge 4	F 203	3	
	DON also indicated	bolicy information herself. The that she would check on the erage letter for Resident #171.			
F 204 SS=D	483.12(a)(7) PREP	-	F 204	1	8/18/15
	orientation to reside	de sufficient preparation and ents to ensure safe or discharge from the facility.			
	the administrator of written notification p to the State Survey ombudsman, reside legal representative responsible parties	y closure, the individual who is the facility must provide prior to the impending closure Agency the State LTC ents of the facility, and the es of the residents or other , as well as the plan for the ate relocation of the residents, .75(r).			
	by:	NT is not met as evidenced			
	and staff interviews safe/orderly dischar	eview, home health agency the facility failed to provide a rge for to one of one sample riewed for discharge.		Preparation and/or execution of this of correction does not constitute admission or agreement by the provi that the alleged deficiencies did, in fa exist. This plan of correction is filed	der lict
	Findings included:			evidence of the facilities desire to con with the requirements and to provide	mply
	5/11/2015 the active	admitted to the facility on e diagnoses included Lack of rtension, Cerebrovascular ty Disorder.		 quality care. 1. Resident #171 no longer resides the facility. 2. For those with potential: 	at
	5/18/2015 revealed cognitively intact an	imum Data Set dated Resident #171 was Id required extensive mobility and transfer. He had		 2. For those with potential: A) An audit tool was developed on 08/13/2015, which addresses the preparation for safe/orderly discharge process. This tool includes but is not 	

Facility ID: 923377

If continuation sheet Page 5 of 11

(EACH DEFICIENCY	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345229 TEMENT OF DEFICIENCIES	A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/30/2015
SUMMARY STA (EACH DEFICIENCY	,		STREET ADDRESS, CITY, STATE, ZIP CODE	07/30/2015
SUMMARY STA (EACH DEFICIENCY	,	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	07/30/2015
SUMMARY STA (EACH DEFICIENCY				
SUMMARY STA (EACH DEFICIENCY				
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES		1101 NORTH MORGAN STREET SHELBY, NC 28150	
	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLET
ontinued From pa	ge 5	F 20)4	
hearing deficit; w eds; had behavio riod; that included mptoms directed havioral symptom review of a progre- vealed Resident # cility for short tern ented to person, 71 reported he do xious but felt like eds so much help SD) and family, w erview, encourag operative with the gain some of his p esident #171 refus isodes of yelling a lped him despite en. Resident #172 aff, bang his call lit attention. review of Social S 21/2015 revealed en set. review of Social S 21/2015 at 12:49p 22/2015 at 12:53F 71 was discharge ther than 5/22/207 esident #171 was	vas able to communicate his or during the 7 day look back d other verbal behavior toward other and other ns not directed toward others. ess note dated 5/18/2015 4171 was admitted to the in therapy and was alert and place, and time. Resident bes not feel depressed or he was a failure because he b. The Social Service Director /ho was present for an ed Resident #171 to be erapy and staff so that he may prior function. On 5/15/2015, sed therapy, had multiple at staff and stating that no one staff answering his call light 1 got irritated yelled out at ight and remote on the table Services Progress Note dated that no discharge date had Services Progress Note dated om (Recorded as late Entry on PM) revealed that Resident ed home today [5/21/2015] 15. The SSD explained that no longer an active participant		 limited to; Notice of transfer/diswriting, location being transferred/discharged to, and appeal, involvement in local adprotective services, etc. B) All resident discharged in the days were reviewed/audited for compliance with appropriate disprocedures. This has been acced by the Director of Nursing, Staff Development Coordinator, and Care Coordinator. 3. Systemic Changes: A) An in-service will be completed in the discharge proceed these staff members who are or of absences or who are otherwith the facility, the in-service will be completed prior to returning to assignment. B) All transfers/discharges will discussed daily in the Administre meeting and weekly with the the manager and/or designee. Any in planned transfers/discharges communicated with the approprinterdisciplinary involvement as occur. C) For residents and/or family representatives who wish to chascheduled transfer/discharge different for the place: interdisciplinary team meeting, 	the right to ult ne last 60 scharge complished f the Clinical eted on vho are ss. For n a leave ise out of their l be rative erapy v changes s will be riate they ange ates, the notification
	hearing deficit; w eds; had behavior riod; that included mptoms directed havioral symptom eview of a progre- vealed Resident # cility for short term ented to person, 71 reported he do xious but felt like eds so much help SD) and family, w erview, encourag operative with the gain some of his sident #171 refus isodes of yelling a ped him despite en. Resident #17 ff, bang his call li attention. eview of Social S 9/2015 revealed en set. eview of Social S 2/2015 at 12:53F 71 was discharge her than 5/22/20 sident #171 was therapy. Residen manded to go ho e family reported me and get Residen	hearing deficit; was able to communicate his eds; had behavior during the 7 day look back riod; that included other verbal behavior inptoms directed toward other and other havioral symptoms not directed toward others. eview of a progress note dated 5/18/2015 realed Resident #171 was admitted to the sility for short term therapy and was alert and ented to person, place, and time. Resident 71 reported he does not feel depressed or xious but felt like he was a failure because he eds so much help. The Social Service Director SD) and family, who was present for an erview, encouraged Resident #171 to be operative with therapy and staff so that he may gain some of his prior function. On 5/15/2015, sident #171 refused therapy, had multiple isodes of yelling at staff and stating that no one lped him despite staff answering his call light en. Resident #171 got irritated yelled out at aff, bang his call light and remote on the table attention.	hearing deficit; was able to communicate his eds; had behavior during the 7 day look back riod; that included other verbal behavior mptoms directed toward other and other havioral symptoms not directed toward others. eview of a progress note dated 5/18/2015 realed Resident #171 was admitted to the eility for short term therapy and was alert and ented to person, place, and time. Resident 71 reported he does not feel depressed or kious but felt like he was a failure because he eds so much help. The Social Service Director SD) and family, who was present for an erview, encouraged Resident #171 to be operative with therapy and staff so that he may jain some of his prior function. On 5/15/2015, sident #171 refused therapy, had multiple isodes of yelling at staff and stating that no one lped him despite staff answering his call light en. Resident #171 got irritated yelled out at ff, bang his call light and remote on the table attention. eview of Social Services Progress Note dated 9/2015 revealed that no discharge date had en set. eview of Social Services Progress Note dated 11/2015 at 12:49pm (Recorded as late Entry on 12/2015 at 12:53PM) revealed that Resident 71 was discharged home today [5/21/2015] her than 5/22/2015. The SSD explained that sident #171 was no longer an active participant therapy. Resident #171 yelled, screamed, and manded to go home and was not redirectable. e family reported to the SSD that they would me and get Resident #171 but needed	 hearing deficit; was able to communicate his eds; had behavior during the 7 day look back riod; that included other verbal behavior mptoms directed toward other and other havioral symptoms not directed toward others. eview of a progress note dated 5/18/2015 realed Resident #171 was admitted to the discharge or protective services, etc. B) All resident discharged in the days were reviewed/audited for compliance with appropriate dis procedures. This has been act by the Director of Nursing, Staff 21 reported he does not feel depressed or kious but felt like he was a failure because he eds so much help. The Social Service Director 520) and family, who was present for an erview, encouraged Resident #171 to be operative with therapy and staff so that he may jain some of his prior function. On 5/15/2015, sident #171 refused therapy, had multiple isodes of yelling at staff and stating that no one ped him despite staff answering his call light and remote on the table attention. eview of Social Services Progress Note dated 9/2015 revealed that no discharge date had en set. eview of Social Services Progress Note dated 12/2015 at 12:53PM) revealed that Resident 71 was no tonger an active participant that sident #171 yelled, screamed, and manded to go home and was not redirectable. e family reported to the SSD that they would me and get Resident #171 but needed limited to; Notice of transfer/discharge of the specific to the appropriate discharge for an ending. All transfers/discharges will discussed daily in the Administing that no oligen an active participant that specific part involvement as oncer. For resident #171 was no longer an active participant the appropriate disciplinary itam meeting, of the local adult protective sem indicated, and coordination of s with local Home Health agency.

Facility ID: 923377

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 E SURVEY PLETED
		IDENTIFICATION NOWBER.	A. BUILDI	NG _			C
		345229	B. WING				
NAME OF I	PROVIDER OR SUPPLIER	-		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RI	ESOURCES - SHELB	Y			101 NORTH MORGAN STREET HELBY, NC 28150		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 204	his personal wheel be transferred. All reviewed and med (responsible party) physician office on appointment for Re A review of Social 5/21/2015 at 2:29p #171 would be dise #171 refused to ge verbal aggressive, staff. Referral mad Resident #171. SS appointment but th During an interview home health agend that the procedure #171 was not follow did not received a after Resident #17 5/21/2015. The rep for Home Health se discharge a Home come out to the fac for services. The re facility assessment #171. The represe received a phone of Resident #171 fam initial assessment home. She also in services were not se	Resident #171 family brought chair to the facility so he could discharge paperwork was ications sent home. RP stated she would call the 5/22/2015 to set up a follow up esident #171. Services Progress Note dated on stated (in part) that Resident charged home today. Resident et out of bed for therapy, yelling, physically aggressive with e for Home Health to follow D attempted to make follow up the physician office was closed. with a representative of the cy on 7/29/2015 she revealed for the discharge of Resident wed. The home health agency referral from the facility until 1 was discharged on presentative indicated the policy ervices included: before Health staff member would cility and assess the resident expresentative indicated that a t was not done on Resident ntative also indicated that she call and request for advice from hily before she completes an or first visit to Resident #171 's dicated that home health started within 48 after Resident ged due to the unplanned		04	 A) Will be done by auditing discharwith the newly developed tool as for 100% of all residents transferred/discharged will be revier for four weeks, 50% of all residents transferred/discharged will be revier for four weeks, and 25% of all residents. B) Ongoing audits will be determine the results of the prior audits. Completion of audits will be on November 6, 2015. Results of the a will be reviewed a monthly QAPI m and weekly in the Administrative Numeetings. Changes in the Perform Improvement Plan will be accompliately when necessary. 	llows: wed lents wed hed by audits eeting ursing ance	
	#171 was discharg referral from the fa	ed due to the unplanned					

If continuation sheet Page 7 of 11

		AND HUMAN SERVICES				FORM	09/18/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI COM	E SURVEY IPLETED
		345229	B. WING				C 30/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK R	ESOURCES - SHELB	(101 NORTH MORGAN STREET HELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 204	2pm she revealed s family and informed been refusing phys needed to be disch informed Resident is be discharged on 5 the SSD that he wo (5/21/2015). The St followed the policy if #171 because Resi short term. On 7/30/2015 an in department revealed discharged from the department revealed discharge at his neit During an interview (DON) on 7/30/201 expectation would it the facility discharg expectation would it communication bet departments. The I have to review the 483.25 PROVIDE C HIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psychol	she called Resident #171's d them that Resident #171 had ical therapy and that he arged. The SSD indicated she #171's family that he could i/22/2015. The family informed buld be pick up today SD also stated that she for discharging a Resident ident #171 was only here for terview with the therapy ed that Resident #171 was not erapy services. The therapy ade aware of resident #171's xt scheduled appointment. with the Director of Nursing 5 at 3pm she revealed her be that the SSD would follow ie policy for all residents. Her include proper notification and ween disciplines and DON indicated that she would policy information herself. CARE/SERVICES FOR	F 2	204			8/18/15

Facility ID: 923377

If continuation sheet Page 8 of 11

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	· · ·	PLETED
						C
		345229	B. WING			30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
		,		1101 NORTH MORGAN STREET		
	ESOURCES - SHELB	r		SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 309	Continued From no	ao 9		00		
F 309	Continued From pa	-	F 3	09		
		NT is not met as evidenced				
	by: Based on record re	eview and staff interview the		Preparation and/or execution	on of this plan	
		w physician recommendation		of correction does not const		
		ow up orthopedic appointment		admission or agreement by		
		Resident #188) with a		that the alleged deficiencies	did, in fact	
	fractured humerus	and splint.		exist. This plan of correctio		
	Findings included:			evidence of the facilities des		
		admitted to the facility on		with the requirements and to	o provide high	
		harged to an acute care		quality care.		
		15. Her diagnosis included scle Weakness, Vitamin D		1. Resident #188 no longe	r resides at	
	deficiency, and Anx			the facility.	r resides at	
		Set dated 4/4/2014 revealed		2. For those with potential		
		moderately cognitively		A) An audit tool was develo		
		ired extensive assistance from		08/13/2015, which address		
		physical assistance for bed		scheduling follow up appoin		
	mobility, transfers.			outside of facility. This inclu		
		11/25/2014 revealed Resident		limited to; origin of order, far		
		f right arm and shoulder pain.		notification, and if the reside	ent went to the	
		obile x-ray report included a		appointment.	ta fan tha laat	
		re [shatters into three or more humerus [long bone of the		B) All resident appointmen		
	upper arm].			30 days were reviewed/aud they were attended by the re		
		aled a complete facility		Director of Nursing, Staff De		
		11/26/2014. Resident #188		Coordinator, and the Clinica		
		to her right arm and right		Coordinator completed this		
		ements reported nothing		C) 100% of consults for res	sident for last	
		or Resident #188. The staff		30 days were reviewed/audi		
		mechanical lift for transfers. A		the ordered follow up appoir		
		ed a right humerus fracture.		made by staff and attended	by the	
		sent to orthopedics.		resident.	as doveloped	
		ultation dated 11/26/2014 merus fracture and a		 D) New appointment log w with the following informatio 		
		f follow up in 1 to 2 weeks.		resident¿s name, ordering r		
		sultation dated 12/4/2014		appointment needed (includ		
		f status post right humerus		frame), family notification, a		
		ning pain getting better. Hand		appointment attended by re-		

Facility ID: 923377

If continuation sheet Page 9 of 11

	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
	ST CORRECTION	IDENTIFICATION NOWBEN.	A. BUILDIN	IG		C
		345229	B. WING _			_ 30/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RI	ESOURCES - SHELB	(1101 NORTH MORGAN STREET SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 309	Continued From pa	-	F 30	9 3. Systemic Changes:		
	A nurse note dated orthopedic office ca appointment sched days after Resident appointment.] The in received a call from about the swelling of The responsible pa she was not aware #188 was assessed new issue. The RP orthopedic appointment. A record review of the medical record) resist months of Decemb February 2015 did in follow up appointment On 7/30/2015 at 2:5 staff member who we	12/10/2014 revealed the		 A) A new process for appointed developed that included the foll upon admission, the informatio will be reviewed by the Clinical Coordinator/Charge nurse for the necessary appointments and log newly created form. For estable residents, with any change of c that requires the resident to go medical services, and/or physic the information will also be revied the Clinical Care Coordinator/C Nurse and logged, b) this log w checked daily by the staff mem assigned to make appointment the Clinical Care Coordinator/C Nurse to ensure compliance with scheduled appointments. B) In the event of a cancelled appointment by staff, resident, family representative, the Clinical Caree Nurse, will 	owing; a) n packet Care gged on ished ondition out for ian orders, ewed by harge ill be ber s, and by harge th	
	procedure for schee The nurse staff wro appointment book and placed it in the reported she referre and if there was an she made it. The w save the hand writte January 2015 and F and there was no e to be scheduled for ward clerk reported nursing staff pinning station and not putt book causing appoint	duling resident appointments. the the order or referral in the "blue book " or made a copy appointment book. She ed to her appointment book appointment to be made then ard clerk reported she did not en log from December 2014. February 2015 were reviewed ntry/referral for Resident #188 an orthopedic follow up. The there was a problem with the g up referrals at her work ing them in the appointment intments to not be scheduled. 58 PM An interview with Nurse		 communicate with the consultir office for an appropriate follow appointment time. The new app will then be logged for monitorin C) With cancellations, the follow information will be noted in the progress notes; the person who the appointment, the notification representative, the new follow of appointment and any other releatinformation. D) If a family representative and resident refuses to attend and/of the same appointment twice, and interventions will be care planninclude, but not limited to, assist 	up pointment ng. vwing resident¿s o cancelled n of family up vant nd/or or cancels opropriate ed to	

Facility ID: 923377

TATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(3) DATE	0938-039 SURVEY PLETED
		345229	B. WING				, 0/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RI	ESOURCES - SHELB	(1101 NORTH MORGAN STREET SHELBY, NC 28150				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 309	dropped the referration nurse. She reported nurse when Reside the charge nurse with paperwork [commu- including referral re- nursing staff when facility. The charge transcribing the phy- recommendations fat appointment in the Nurse #1 was unab- orthopedic follow up #188 as recomment physician on her 12 A record review of ta appointment log for appointment on 11/ 12/4/2014 status ar canceled, and 3/4/2 An interview on 7/3 Director of Nursing physician orders to staff and collaborat the event appointm cancelled so the fat the families. The Di- " appointment to be acceptable to pin o orders on the wall.	The provided she expected be reviewed by the nursing staff of she was the 1st shift charge of she was the 1st shift charge of she was the 1st shift charge of the was the 1st shift charge of the the she was in the facility and as to receive the office visit unication tool from physician commendations] from the a resident returned to the nurse was responsible for visician orders, for referrals, and follow up appointment [blue] book. The to locate a scheduled pappointment for Resident aded by the orthopedic 2/4/2014 appointment. The orthopedic office resident #188 included: 26/2014 status arrived, rived, 12/10/2014 status 2015 status canceled. 0/2015 at 3:20 PM with the revealed she expected be reviewed by the nursing e with the scheduling staff in ents are not scheduled or cility could communicate with ON reported the facility had an e made book. " It was not r tack resident referrals or The DON 's expectation was w the procedure for scheduling	F 3	09	Social Services Director, Ombudsmer and Adult Protective Services if indica E) Nursing Staff and any interdiscipli staff involved with scheduling consults and follow up appoints will be in servic by 08/18/2015 for this new process. F those staff members who are on leave absences or who are otherwise out of facility, the in-service will be complete prior to returning to their assignment. 4. Monitoring for future compliance: A) Will be done by auditing consult orders with the newly developed audit as follows: 100% of consults for four weeks, 50% of consults for four week 25% of consults for four weeks. B) Ongoing audits will be determined the results of the prior audits. 5. Completion of audits will be November 06, 2015. Results of the au will be reviewed at monthly QAPI mee and at the weekly Administrative Nurs Meetings. Changes in the Performan Improvement Plan will be accomplish when necessary.	ated. linary s iced For re of f the ed t tool cs, d by udits eting sing nce	

Facility ID: 923377

If continuation sheet Page 11 of 11