CENTERS	OR MEDICARE & MEDICAID SERVICES			A FURW			
STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE		PROVIDER#	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs			A. BUILDING:	COMPLETE:			
		345429	B. WING	7/20/2017			
NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - PINELAKE		801 PINEHURST	STREET ADDRESS, CITY, STATE, ZIP CODE 801 PINEHURST AVENUE CARTHAGE, NC				
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENC	ZIES					
F 157	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)						
	(g)(14) Notification of Changes.						
	(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-						
	(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;						
	(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);						
	(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or						
	(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).						
	(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.						
	(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-						
	(A) A change in room or roommate assignment as specified in §483.10(e)(6); or						
	(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.						
	(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have accurate Responsible Party contact information for one of two sampled residents (Resident #19). The findings included:						
	On 7/18/17 at 9:14 AM, a telephone family interview was conducted regarding Resident #19. The contact information for the Responsible Party for Resident #19 had been obtained from the face sheet located on the medical record and verified on the computerized chart. The family member that answered the telephone stated the Responsible Party information was no longer correct as the Responsible Party had expired two years ago. The family member stated another relative was now the Responsible Party.						
	On 7/18/17 at 9:57 AM, an interview was conducted with MDS Nurse #1 who stated the social worker was responsible for changes to the face sheet and keeping the Responsible Party information up to date. She						

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

The above isolated deficiencies pose no actual harm to the residents

CENTERS FOR MEDICARE & MEDICARD SERVICES		1		71 TORW			
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NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM			A. BUILDING:	COMPLETE:			
FOR SNFs AND NFs				00.11 22.12.			
TOR BINIS AND IN	3	345429	B. WING	7/20/2017			
			B. WING				
NAME OF PROVID	DER OR SUPPLIER	STREET ADDRESS, O	CITY, STATE, ZIP CODE				
PEAK RESOURCES - PINELAKE		801 PINEHURST AVENUE					
		CARTHAGE, NC					
		CHRITINGE, INC	<u> </u>				
ID							
PREFIX							
TAG	SUMMARY STATEMENT OF DEFICIENCIES						
	1						
F 157	Continued From Page 1						
	stated, if the social worker was not available, the Business Office Manager also assisted in keeping the						
	information on the face sheet accurate.						
	information on the face sheet accurate.						
	On 7/18/17 at 10:10 AM, an interview was conducted with the Business Office Manager. She stated she						
	assisted the social worker in making sure the face sheet had the most current information. She said she had						
	worked at the facility about 1 1/2 years. She reviewed the information on the face sheet for Resident #19 and						
	stated she was not aware that the responsible Party information was incorrect.						
	On 7/20/2017 at 10:07 AM, an interview was conducted with the Director of Nursing who stated she expected						
	the contact information to be up to date and accurate.						
	the contact information to be up to take and accurate.						
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