SNATURATION       (M) PROVERSIMAL INTERCINATION NUMBER:       (C) NULTER CONSTRUCTION       (C) NULTER CONSTRUCTION NULTER CONSTRUCTION       (C) NULTER CONSTRUCTION NULTER CONSTRUCTION NULTER CONSTRUCTION SHOULD BE CONSTRUCTION NUTTER CONSTRUCTION NULTER CONSTRUCTION SHOULD BE CONSTRUCTION NUTTER CONSTRUCTION NUTTER CONSTRUCTION SHOULD BE CONSTRUCTION NUTTER CONSTRUCTION SHOULD BE CONSTRUCTION NULTER CONSTRUCTION NULTER CONSTRUCTION NULTER CONSTRUCTION NULTER CONSTRUCTION NULTER CONSTRUCTION NUTTER CONSTRUCTION NULTER CONSTRUCTION NULTER CONSTRUCTION NULTER CONSTRUCTION NULTER CONSTRUCTION NUL		-	ID HUMAN SERVICES				FORM APPROVED
AND FLAN OF CORRECTION     IDENTIFICATION NUMBER     A BUILDING     COMPLETED       348337     B WING     STREET ADDRESS, CLUED STREET       PEAK RESCURCES - ALAMANCE, INC       SUMMARY STATUMENT OF DEPERINGED BY FLL       IN COLLED STREET       SUMMARY STATUMENT OF DEPERINGED BY FLL     ID       PREM RESCURCES - ALAMANCE, INC       INTERCENT OF DEPERINGED BY FLL       INTERCENT OF DEPERINGE ADD BY FLL       PREM RESCURCES IN THE PRECEDED BY FLL       INTERCENT OF DEPERINGENT ON MUST BE PRECEDED BY FLL       PREM RESCURCES IN THE PRECEDED BY FLL       INTERCENT OF DEPERINGENT ON MUST BE PRECEDED BY FLL       PREM RESCURCES IN THE PRECEDED BY FLL       INTERCENT ON THE PRECEDED BY FLL       IDENTFINIANT OF DEPERING AND THE PRECEDED BY FLL       INTERCENT ON THE PRECEDED BY FLL       INTERCENT ON THE PRECEDED BY FLL       INTERCENT ON THE PRECEDED BY FLL       INTERCENT       THE SUMMER TO PREMIMENT OF DEPERING AND THE							OMB NO. 0938-0391
INME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, 2P CODE       PEAK RESOURCES - ALAMANCE, INC     ISTREET ADDRESS, CITY, STATE, 2P CODE       (M) D     SUMMARY STATEMENT OF DEFICIENCIES     ISTREET ADDRESS, CITY, STATE, 2P CODE       (PAR)     SUMMARY STATEMENT OF DEFICIENCIES     IP       TAG     INITIAL COMMENTS     PREIX       F 000     INITIAL COMMENTS     F 000       The survey team entered the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the facility on 1/2/18 to conduct annual recertification survey and was unable to return to the survey team returned to the facility on 1/8/18 and Revision CFR(s): 483.21(b)(2)/1 comprehensive Care Plans §483.21(b)(2) A comprehensive care plan ming and the resident.     F 657       2/6/18     SeeD     CFR(s): 433.21(b)(2)(i)(iii)       S483.21(b)(2) A comprehensive care plan ming and the resident mode to resident's medical record if the participlano no it the resident care plan. <td< td=""><td></td><td></td><td></td><td>` '</td><td></td><td></td><td></td></td<>				` '			
PEAK RESURCES - ALAMANCE, INC         SUMMARY STATEMENT OF DEFICIENCIES INCLUENCE STREET (RAHAM, NC 27253           CMUID TAG         SUMMARY STATEMENT OF DEFICIENCIES (REGULTIONY OR LSC DENTIFYING INFORMATION)         D PEERX TAG         D OPEERX (REGULTIONY OR LSC DENTIFYING INFORMATION)         D PEERX TAG         D OPEERX (REGULTIONY OR LSC DENTIFYING INFORMATION)         D PEERX TAG         D OPEERX (REGULTIONY OR LSC DENTIFYING INFORMATION)         P PEERX TAG         D OPEERX (REGULTIONY OR LSC DENTIFYING INFORMATION)         D PEERX TAG         D OPEERX (REGULTIONY OF CARACINES TAG         D OPEERX (REGULTIONY OF CARACINES TAG         D OPEERX TAG         D OPEERX TAG <thd OPEERX TAG         D OPEERX TAG</thd 			345337	B. WING			01/09/2018
PEAK RESOURCES - ALAMANCE, INC         GRAHAM, NC 2723           (X4) U PREFIX NG         Isummery stratement of deficiencies (concentration was the reflection ary rule reconstruction of the component of the comparison of the component of the component of the component of the comparison of the component of the comparison of the component of the component of the component of the component of the conduct and the resident component of the conduct and completed the survey on 19/18. Event ID W4WV11         F 657         F 657           Stable OFFR(s) 483.21(b)(2) A comprehensive care plan must be- (1) Developed within 7 days after completion of the component of the componential to co- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record the participation of the resident and the resident's needs or as requested by the resident. (ii)Reviewed and revised by the interdisciplinary team after each assessment. (iii)Reviewed and revised by the interdisciplinary team after each as	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE	
CANID PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES ILEAD IDEFICIENCY MUST BE PRECEDED BY FULL REGULTORY OR LSCIDENT FUND REPARATION)         ID PREFX TAG         PROMORES PLAN OF CORRECTION (EACH CORRECTION CROSS-REFERENCE) TO THE APPOPRIATE DEFICIENCY         OWN COMELTION (EACH CORRECTION (EACH CORRECTION (EACH CORRECTION CROSS-REFERENCE) TO THE APPOPRIATE DEFICIENCY         OWN COMELTION (EACH CORRECTION (EACH CORRECT			INC		215 COLLEGE STREET		
PREFIX TXG         LEACH OBFIGENCY MUST BE PRECEDED BY FULL RECOLLIGING YOLDS CIDENTFYING INFORMATION)         PREFX IXG         CEACH OBFIGURA ACTION SHOULD BE CROSS-REFERENCE OT OTHE APPROPRIATE         COMPLETING DEFICIENCCY           F 000         INITIAL COMMENTS         F 000         F 000         The survey team entered the facility on 1/2/18 to conduct annual recertificity and was unable to return to the facility on 1/5/18 due to adverse weather of anow and unsafe road conditions. The survey team returned to the facility on 1/6/18 and completed the survey on 1/9/18. Event ID W4WV11         F 657         Z/6/18           F 657         CFR(s): 483.21(b)(2)(f)(iii)         F 657         Z/6/18           §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive Care Plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not eascessment. (iii) Prepared by an interdisciplinary team, that includes but is not participation of the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent participation of the resident's medical record if the participation of the resident. (iii) Prepared participation of the resident's medical record if the participation of the resident. (C) Other appropriate staff or professionals in disciplines as determined on register scare plan. (F) Other extent price by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment. (iii)Reviewed and revised by the interdisciplinary team after each assessment. (iii)Reviewed and revised by the interdisciplinary team after each assessment. (iii)Reviewed and revised by the interdisciplinary team after each assessment. (	PEAK RE	SOURCES - ALAMANCE	, INC		GRAHAM, NC 27253		
The         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         DATE           F 000         INITIAL COMMENTS         F 000         F 000         The survey team entered the facility on 1/2/18 to conduct annual recertificivation survey and was unable to return to the facility on 1/3/18 due to adverse weather of snow and unsafe road conditions. The survey team entured to the facility on 1/8/18 and completed the survey on 1/8/18. Event ID W4WV11         F 657         Z/6/18           F 657         Care Plan Timing and Revision         F 657         S 483.21(b)(2) Comprehensive Care Plans 548.21(b)(2) A comprehensive care plan must be- (I) Developed within 7 days after completion of the comprehensive assessment.         F 657         Z/6/18           (B) A registered nurse with responsibility for the resident.         (C) A nurse aide with responsibility for the resident.         F 657         D and the resident's medical record if the participation of the comprehensive assessment.         F 657           (D) A member of food and nutrition services staff.         (C) A nurse aide with responsibility for the resident.         F 657           (D) A member of food and nutrition services staff.         (C) To the extent precisionals in disciplines as determined to the resident.         F 657           (D) A member of food and nutrition resident's regident's care plan.         F 657         F 657           (D) A member of food and nutrition services staff.         (C) To the extent precicable, the participation of the resi	(X4) ID						
The intervention of Excellent intervention     The survey team entered the facility on 1/2/18 to conduct annual recertificity and on 1/5/18 due to adverse weather of snow and unsele road conditions. The survey team returned to the facility on 1/5/18 and completed the survey on 1/3/18. Event ID WWWV11     F 657       F 667     Care Plan Timing and Revision Systa 21(b)(2) Comprehensive care plans sta3.21(b)(2) Comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.     F 657       (B) A registered nurse with responsibility for the resident.     (C) A nurse aide with responsibility for the resident.     F 10 the extent practicable in a resident's medical record fit the participation of the resident and the resident's needs on a precisioal of the participation of the resident.     F 10 the extent practicable in a resident's medical record if the participation of the resident.       (F) O To the extent practicable in the resident's and their resident and the resident's needs or as requested by the interdisciplinary team after each assessment.       (F) O ther appropriate staff or professionals in disciplines as determined by the resident.       (F) O ther appropriate staff or professionals in disciplines as determined by the resident.       (F) O ther appropriate staff or professionals in disciplines as determined by the resident.       (B) Reverted and revised by the interdisciplinary team after each assessment.							
The survey team entered the facility on 1/2/18 to conduct annual recertificvation survey and was unable to return to the facility on 1/5/18 due to adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/8/18. Event ID W4WV11F 6572/6/18F 657Care Plan Timing and Revision CFR(s): 483.21(b)(2(i)-(iii)F 6572/6/18§483.21(b)(2) A comprehensive Care Plans \$483.21(b)(2)(a) comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.F 6572/6/18(ii) Prepared by an interdisciplinary team, that includes but is not limited to (c) A nurse aide with responsibility for the resident.(i) Prepared by an interdisciplinary team, that includes but is not limited to (c) A nurse aide with responsibility for the resident.(i) Prepared by an interdisciplinary team, that includes but is not limited to (c) A nurse aide with responsibility for the resident.(i) A registered nurse with responsibility for the resident.(b) A registered nurse with responsibility for the resident.(ii) A member of food and nutrition services staff.(c) To the attending physician. (f) Other appropriate staff or professionals in disciplines as determined or as requested by the resident's medical record if the participation of the resident and their resident.(f) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as a equested by the interdisciplinary team after seak basessment, including both the comprehensive and quarterly review assessments.	IAG			IAG			
The survey team entered the facility on 1/2/18 to conduct annual recertificvation survey and was unable to return to the facility on 1/5/18 due to adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/8/18. Event ID W4WV11F 6572/6/18F 657Care Plan Timing and Revision CFR(s): 483.21(b)(2(i)-(iii)F 6572/6/18§483.21(b)(2) A comprehensive Care Plans \$483.21(b)(2)(a) comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.F 6572/6/18(ii) Prepared by an interdisciplinary team, that includes but is not limited to (c) A nurse aide with responsibility for the resident.(i) Prepared by an interdisciplinary team, that includes but is not limited to (c) A nurse aide with responsibility for the resident.(i) Prepared by an interdisciplinary team, that includes but is not limited to (c) A nurse aide with responsibility for the resident.(i) A registered nurse with responsibility for the resident.(b) A registered nurse with responsibility for the resident.(ii) A member of food and nutrition services staff.(c) To the attending physician. (f) Other appropriate staff or professionals in disciplines as determined or as requested by the resident's medical record if the participation of the resident and their resident.(f) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as a equested by the interdisciplinary team after seak basessment, including both the comprehensive and quarterly review assessments.		1					
The survey team entered the facility on 1/2/18 to conduct annual recertificization survey and was unable to return to the facility on 1/5/18 due to adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/8/18. Event ID W4WV11F 6572/6/18F 657Care Plan Timing and Revision SS=DF 6572/6/182/6/18§483.21(b)(20) Comprehensive Care Plans \$483.21(b)(20) Comprehensive Care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.F 6572/6/18(ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician.F 6572/6/18(b) A registered nurse with responsibility for the resident.F 00 and nutrition services staff.F 00 and nutrition services staff.(b) A member of food and nutrition services staff.(C) To the extent practicable, the participation of the resident and the resident sergresentative(s). A nexplanation must be included in a resident's medical record if the participation of the resident and ther resident of the resident and not practicable for the development of the resident and ther is presentative is determined not practicable for the development of the resident and their assessment.(f) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident's needs or as requested by the resident's needs or as sessment.(g) Reviewed and revised by the interdisciplinary team after each assessment.(iii) Reviewed and revised by the interdisciplinary team after each assessment.(iii) Reviewed and revised by the hit condication of the comprehensive and qu	F 000			<b>_</b>	00		
conduct annual recetificivation survey and was unable to return to the facility on 1/5/18 due to adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/8/18 and completed the survey on 1/9/18. Event ID W4WV11F 6572/6/18F 657Care Plan Timing and RevisionF 6572/6/18SS=DCFR(s): 483.21(b)(2)(1)(iii)\$483.21(b)(2) comprehensive Care Plans \$483.21(b)(2) comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(5). An explanation must be included in a resident's medical record [the participation of the resident and their resident of the aresident setter index to the resident and their resident of the resident and their settion of the resident and the resident the here is determined not practicable for the development of the resident setter plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident set or as requested by the resident's needs or as requested by the resident's needs or as requested by the resident the resident setsement, including both the comprehensive and quarterly review assessments.line to the dow long the setsement is determined not practicable for the development of the resident setsement including both the comprehensive and quarterly review assessments.line to the setsement is determined setsement is de	F 000			FU	00		
conduct annual recetificivation survey and was unable to return to the facility on 1/5/18 due to adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/8/18 and completed the survey on 1/9/18. Event ID W4WV11F 6572/6/18F 657Care Plan Timing and RevisionF 6572/6/18SS=DCFR(s): 483.21(b)(2)(1)(iii)\$483.21(b)(2) comprehensive Care Plans \$483.21(b)(2) comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(5). An explanation must be included in a resident's medical record [the participation of the resident and their resident of the aresident setter index to the resident and their resident of the resident and their settion of the resident and the resident the here is determined not practicable for the development of the resident setter plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident set or as requested by the resident's needs or as requested by the resident's needs or as requested by the resident the resident setsement, including both the comprehensive and quarterly review assessments.line to the dow long the setsement is determined not practicable for the development of the resident setsement including both the comprehensive and quarterly review assessments.line to the setsement is determined setsement is de							
unable to return to the facility on 1/5/18 due to adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/8/18 and completed the survey on 1/9/18. Event ID W4WV112/6/18F 657CFR(s): 483.21(b) (2)(i)-(iii)F 657SS=DCFR(s): 483.21(b) Comprehensive Care Plans §483.21(b) Comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.F 657(ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician.F 657(b) A registered nurse with responsibility for the resident.(c) A nurse aide with responsibility for the resident.(b) Charter a care plan.(c) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident representative is determined not practicable for the development of the resident's are plan.(f) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident's needs or as requested by the resident's needs or as requested by the interdisciplinary team after each assessment.		The survey team ent	ered the facility on 1/2/18 to				
adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/8/18 and completed the survey on 1/9/18. Event ID W4WV11 SS=D CFR(s): 483.21(b)(2)(i)-(iii) \$483.21(b) Comprehensive Care Plans \$483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident exident exident of the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and the resident's representative is determined not practicable for the development of the resident and the resident staff or professionals in disciplines as determined by the resident or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessments.		conduct annual recer	tificvation survey and was				
conditions. The survey team returned to the       facility on 1/8/18 and completed the survey on       1/9/18. Event ID W4WV11         F 657       Care Plan Timing and Revision       F 657       2/6/18         SS=D       CFR(s): 483.21(b)(2)(1)-(iii)       \$483.21(b)(2)(1) - (iii)       \$483.21(b)(2) A comprehensive Care Plans         syst83.21(b)(2) A comprehensive care plan must       be-       (i) Developed within 7 days after completion of       the         (ii) Prepared by an interdisciplinary team, that       includes but is not limited to       (A) The attending physician.         (B) A registered nurse with responsibility for the       resident.       (D) A member of food and nutrition services staff.         (D) A member of food and nutrition services staff.       (D) A member of food and nutrition services staff.       (F) To the extent practicable, the participation of         the resident.       (D) A member of food and nutrition services staff.       (F) To the extent practicable, the participation of the resident and the resident's representative(s).         An explanation must be included in a resident's medical record if the participation of the resident's care plan.       (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident's needs or as requested by the resident.         (F) Other appropriate staff or professionals in disciplinary team after each assessment.       (ii)Reviewed and revised by the interdisciplinary team after each assessments. <td></td> <td>unable to return to the</td> <td>e facility on 1/5/18 due to</td> <td></td> <td></td> <td></td> <td></td>		unable to return to the	e facility on 1/5/18 due to				
facility on 1/8/18 and completed the survey on 19/18. Event ID W4WV11       F657       2/6/18         F 657       CFR(s): 483.21(b)(2)(i)-(iii)       F657       2/6/18         §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- <ul> <li>(i) Developed within 7 days after completion of the comprehensive assessment.</li> <li>(ii) Prepared by an interdisciplinary team, that includes but is not limited to-             <li>(A) The attending physician.</li> <li>(B) A registered nurse with responsibility for the resident.</li> <li>(C) A nurse aide with responsibility for the resident.</li> <li>(C) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's medical record if the participation of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's medical record are vised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </li></ul>		adverse weather of s	now and unsafe road				
19/18. Event ID W4WV11       F 657       Care Plan Timing and Revision       F 657         SS=D       CFR(s): 483.21(b)(2)(i)(-iii)       F 657       2/6/18         \$483.21(b)(2) A comprehensive Care Plans       \$483.21(b)(2) A comprehensive care plan must be-       ii)         (i) Developed within 7 days after completion of the comprehensive assesment.       iii) Prepared by an interdisciplinary team, that includes but is not limited to-       iii)         (A) The attending physician.       (B) A registered nurse with responsibility for the resident.       (C) A nurse aide with responsibility for the resident.         (D) A member of food and nutrition services staff.       (E) To the extent practicable, the participation of the resident and the resident's representative(s).       An explanation must be included in a resident's medical record if the participation of the resident and the resident of the resident and the resident's medical record if the participation of the resident and the resident of the resident and the resident's medical record if the participation of the resident and the resident's needs or as requested by the resident.       (F) Other appropriate staff or professionals in disciplines are determined by the resident's needs or as requested by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.       Iii Review and quarterly review		conditions. The surve	ey team returned to the				
F 657 SS=DCare Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)F 6572/6/18\$483.21(b) Comprehensive Care Plans \$483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident.2/6/18(C) A nurse aide with responsibility for the resident. (C) A nurse aide with responsibility for the resident.(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident. (F) Other appropriate staff or professionals in disciplines as determined not practicable for the development of the resident. (F) Other appropriate staff or professionals in disciplines as determined by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.Image: Staff or Stafff		facility on 1/8/18 and	completed the survey on				
SS=D       CFR(s): 483.21(b)(2)(i)-(iii)         \$483.21(b)(2) A comprehensive care plans         \$483.21(b)(2) A comprehensive care plan must         be-         (i) Developed within 7 days after completion of         the comprehensive assessment.         (ii) Prepared by an interdisciplinary team, that         includes but is not limited to         (A) The attending physician.         (B) A registered nurse with responsibility for the         resident.         (C) A nurse aide with responsibility for the         resident.         (D) A member of food and nutrition services staff.         (E) To the extent practicable, the participation of         the resident and the resident's representative(s).         An explanation must be included in a resident's         medical record if the participation of the         the resident representative is determined         not practicable for the development of the         resident's care plan.         (F) Other appropriate staff or professionals in         disciplines as determined by the interdisciplinary         team after each assessment, including both the         comprehensive and quarterly review         assessments.		1/9/18. Event ID W4	WV11				
<ul> <li>§483.21(b) Comprehensive Care Plans</li> <li>§483.21(b)(2) A comprehensive care plan must be-</li> <li>(i) Developed within 7 days after completion of the comprehensive assessment.</li> <li>(ii) Prepared by an interdisciplinary team, that includes but is not limited to</li> <li>(A) The attending physician.</li> <li>(B) A registered nurse with responsibility for the resident.</li> <li>(C) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident.</li> <li>(ii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>	F 657	Care Plan Timing and	d Revision	F 6	57		2/6/18
<ul> <li>§483.21(b)(2) A comprehensive care plan must be-</li> <li>(i) Developed within 7 days after completion of the comprehensive assessment.</li> <li>(ii) Prepared by an interdisciplinary team, that includes but is not limited to</li> <li>(A) The attending physician.</li> <li>(B) A registered nurse with responsibility for the resident.</li> <li>(D) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's medical record if the participation of the resident be included in a resident's medical record if the participation of the resident and their resident of the resident and the resident of the resident nurse is determined not practicable for the development of the resident and their resident of the resident's medical record if the participation of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>	SS=D	CFR(s): 483.21(b)(2)	(i)-(iii)				
<ul> <li>§483.21(b)(2) A comprehensive care plan must be-</li> <li>(i) Developed within 7 days after completion of the comprehensive assessment.</li> <li>(ii) Prepared by an interdisciplinary team, that includes but is not limited to</li> <li>(A) The attending physician.</li> <li>(B) A registered nurse with responsibility for the resident.</li> <li>(D) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's medical record if the participation of the resident be included in a resident's medical record if the participation of the resident and their resident of the resident and the resident of the resident nurse is determined not practicable for the development of the resident and their resident of the resident's medical record if the participation of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>							
be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.		§483.21(b) Comprehe	ensive Care Plans				
<ul> <li>(i) Developed within 7 days after completion of the comprehensive assessment.</li> <li>(ii) Prepared by an interdisciplinary team, that includes but is not limited to</li> <li>(A) The attending physician.</li> <li>(B) A registered nurse with responsibility for the resident.</li> <li>(C) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>		§483.21(b)(2) A comp	prehensive care plan must				
the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.		be-					
<ul> <li>(ii) Prepared by an interdisciplinary team, that includes but is not limited to</li></ul>		(i) Developed within 7	7 days after completion of				
<ul> <li>includes but is not limited to</li> <li>(A) The attending physician.</li> <li>(B) A registered nurse with responsibility for the resident.</li> <li>(C) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>		the comprehensive as	ssessment.				
<ul> <li>(A) The attending physician.</li> <li>(B) A registered nurse with responsibility for the resident.</li> <li>(C) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>		(ii) Prepared by an int	terdisciplinary team, that				
<ul> <li>(B) A registered nurse with responsibility for the resident.</li> <li>(C) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>							
resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.							
<ul> <li>(C) A nurse aide with responsibility for the resident.</li> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>			e with responsibility for the				
resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.							
<ul> <li>(D) A member of food and nutrition services staff.</li> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>			responsibility for the				
<ul> <li>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>							
the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.							
An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			· · ·				
<ul> <li>medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.</li> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>							
and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.							
not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.							
resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.							
<ul> <li>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.</li> <li>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.</li> </ul>		· ·	e development of the				
disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			staff or professionals in				
or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			•				
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.		•	-				
team after each assessment, including both the comprehensive and quarterly review assessments.							
comprehensive and quarterly review assessments.							
assessments.			-				
		-					
		assessments.					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITI F		(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.

02/02/2018

		ND HUMAN SERVICES MEDICAID SERVICES			FORI	D: 02/15/201 MAPPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		E SURVEY PLETED
		345337	B. WING		01	/09/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	SOURCES - ALAMANCE			215 COLLEGE STREET		
		,, 110		GRAHAM, NC 27253		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 657	Continued From page	e 1	F 65	7		
		Γ is not met as evidenced	1 00			
		on, record review and		This Plan of Correction constit	utes written	
		/ failed to revise care plans		allegation of compliance for the		
		ation of electronic monitoring		deficiencies cited. However, su		
		mechanical lift for 2 of 27		of this Plan of Correction is not		
	sampled residents (F	Residents #33 and #253).		admission that a deficiency exi		
	Eindingo includod:			Plan of Correction is submitted requirements established by st		
	Findings included:	admitted 12/23/15 with		federal law.	ale anu	
		led unspecified dementia				
	with behavioral distu	-		F-657		
		s of left lower extremity, and				
	difficulty walking.			1. Root cause analysis was p	performed	
				by facility to determine the cau	se of the	
		ed 12/09/17 identified		deficient practice. The facility facili		
	Resident #33 as an e	•		follow process for care plan rev		
		of 03/02/16. One of the		secondary to clinical and Interc		
		I was to "equip resident with		Team meeting inconsistencies		
	a device that alarms	when [she] wanders."		addition, staff failed to properly		
	The meet recent Mini	incurre Data Cat (MDC) datad		appropriate staff of change in t		
		imum Data Set (MDS) dated		technique for resident #33. Dire		
	with behavioral symp	evere cognitive impairment		Nursing revised the care plans resident # 253 to include disco		
		or total dependence for		of electronic monitoring device		
	activities of daily livin			and resident #33 to include		
		No wandering was noted on		discontinuation of electronic m	onitoring	
		seven-day look back period		device on 1/9/18 and use of me	echanical	
	and the resident was	not coded for use of a		lifts on 2/1/18. Resident #253	and	
	wander/elopement al	arm.		resident #33 were not adverse	ly affected	
				by the deficient practice.		
		ring device was visible on			and a star to	
	Resident #33 's wris	•		2. The Staff Development Co		
		nroughout the survey, t 10:42 a.m., 01/08/18 at		educate all CNAs to review the profile before providing care to		
	-	at 1:20 p.m., and 01/09/18		proper transfer technique is pe		
	at 9:30 a.m.	at 1.20 p.m., and 0 1/08/10		and if there is an ADL function		
	at 0.00 a.m.			or any other inaccuracy in the	-	
	In an interview on 01	/09/18 at 9:45 a.m., Nurse		profile, the CNA will immediate		

Facility ID: 923271

If continuation sheet Page 2 of 12

		MEDICAID SERVICES					NO. 0938-03
	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,	PLE CONSTRUC		· · · ·	OATE SURVEY COMPLETED
		345337	B. WING				01/09/2018
NAME OF P	ROVIDER OR SUPPLIER	·		STREET ADD	RESS, CITY, STATE, ZIP CODE		
PEAK RE	SOURCES - ALAMANCE	, INC		215 COLLEG GRAHAM, N			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 657	Continued From page	e 2	F 6!	57			
F 657	Aide #4 indicated tha monitoring device. St the resident exiting th Although the resident facility exit door, Nurs near the door in an al door was opened. In an interview on 01, #8 confirmed that Re- electronic monitoring the resident at risk for resident was less mo admitted. b. The care plan for l entry for the use of a safe transfers as nee Date was 09/15/16. The wheelchair of Re- mechanical lift sling p made throughout the at 10:42 a.m., 01/08/ 1:20 p.m., and 01/09/ asked, the resident w	t Resident #33 did not use a ne denied any concern about ne facility unattended. t's room was next to a se Aide #4 had not seen her ttempt to leave when the /09/18 at 11:45 a.m., Nurse sident #33 did not use an device. She did not consider r elopement, stating that the bile now than when first Resident #33 included an "mechanical lift (Hoyer) for ded." The Approach Start esident #33 did not have a oresent during observations survey, including 01/03/18 18 at 12:30 p.m., 01/08/18 at (18 at 9:30 a.m. When vas not able to provide any use of the lift. She indicated	F 6	the resp inaccur comple a referr care pla revised if neces immedi DON/de during of residen time for Clinical weekly address profile f were eo Manage Care pl revisior assess Educati 3. Th Audit 10 profiles	ponsible nurse of the change acy. This education will be ted by 2/6/18. The nurse will al to therapy, as appropriate an and resident profile will be with any changes or inaccu ssary, by the DON/designee lately. In addition, the esignee will review all orders clinical meeting and care plat at profiles will be revised at the r any pertinent changes. IDT At Risk meetings will be he and any identified changes sed in the care plan and resi for accuracy. The MDS nurs ducated by the Regional Cate er on care plan revision proc lan/resident profiles review and swill occur after each ment, including both the ehensive and quarterly revier ments to ensure accuracy. ion was completed on 1/31/ e DON, SDC, and MDS nurs 00% of Care Plans and reside for electronic monitoring de nical lifts and any other	I make e. The erracies, s daily ans and hat id will be ident es re cess. and w 18 ses will dent	
	Aide #3 confirmed that stand and pivot. She the mechanical lift with	/08/18 at 12:50 p.m., Nurse at Resident #33 was able to stated that she did not use th the resident because she could transfer safely with sisting.		accurat This wil ensure residen	racies to ensure the care pla tely reflects the residents sta Il be completed by 2/6/18. 1 continued compliance, 10% at care plans will be reviewed At Risk meeting by the IDT	atus. To of all d at the	
	In an interview on 01/ Occupational Therap	/09/18 at 1:45 p.m., the y (OT) Manager stated that t currently on their caseload.		weekly for two audits v	for four weeks and then bi-w months. The results of these will determine the need for fu ring of the POC. The results	weekly e urther	

Facility ID: 923271

If continuation sheet Page 3 of 12

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/15/2018 MAPPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		345337	B. WING			01/	/09/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RE	SOURCES - ALAMANCE	, INC			15 COLLEGE STREET RAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	2016 and by Physica 2017. She proposed mechanical lift must h Nursing based on the the facility when she indicated that revision improvements in resid discontinuing the med approval of someone nursing services initia In an interview on 01, MDS Coordinator cor behaviors were not p there was no use of a wandering according document. She stated current care plan did elopement risk. She i that nursing staff wen for Resident #33 and an update for her imp indicated that she usu revisions by attending meetings and daily st the units. Staff could change in the care pla any nurse can update point-of-care guides t could initiate an issue In an interview on 01, Director of Nursing the care plan was not lowered elopement ri- stated that an elopem early October showed	seen by OT in December of I Therapy in February of that the use of the nave been initiated by eresident 's readmission to was in decline. She ns to the care plan based on dent condition, i.e., chanical lift, didn 't need the from Rehabilitation when ated the care plan entry. /09/18 at 10:00 a.m., the nfirmed that wandering resent for Resident #33 and a monitoring device for to the latest MDS d she was not aware that the not reflect the lowered ndicated she was not aware e not using a mechanical lift that the care plan needed proved ability to transfer. She ually learned of needed g the daily department and-up clinical meeting on also notify her directly of a an. She further stated that e care plans and but only a registered nurse	F	657	noted and reviewed in the monthly Qu Assurance and Performance Improvement Committee meeting.	Jality	

Facility ID: 923271

If continuation sheet Page 4 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	
		345337	B. WING			01/	09/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PEAK RE	SOURCES - ALAMANCE,	INC			215 COLLEGE STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 657	were not using the me #33 due to her improv The DON shared her staff followed interver care plans and that re- timely manner to keep 2. Resident #253 waa diagnoses that include cerebrovascular accid secondary Parkinson dementia with behavic care was initiated 01// obstructive pulmonary The quarterly MDS da severe cognitive impa- extensive assistance dependence for bathii on the MDS during th period and the resider a wander/elopement The care plan dated 0 #253 as an elopement Date of 01/26/15. One entered was to "equip alarms when [he] war was last reviewed 01// No electronic monitor Resident #253 's wrist observations made the including 01/03/18 at 10:34 a.m., and 01/08 Resident #253 was new wheelchair stationary during the time of the	echanical lift for Resident ved ability to transfer safely. expectation that nursing ntions outlined in resident evisions were done in a or the plans current. Is admitted 02/20/13 with ed sequelae following dent, difficulty walking, 's disease, and unspecified oral disturbance. Hospice 02/17 for end-stage chronic y disease. Ated 10/05/17 recorded airment. He required for ADLs with total ng. No wandering was noted e seven-day look back nt was not coded for use of alarm. 01/05/18 identified Resident th risk with a Problem Start e of the interventions o resident with a device that nders." The nursing problem (03/18. ing device was visible on sts or ankles during iroughout the survey, 11:25 a.m., 01/08/18 at 3/18 at 12:44 p.m.	F	657	7		

Facility ID: 923271

If continuation sheet Page 5 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE	
		345337	B. WING			01/	09/2018
NAME OF P	ROVIDER OR SUPPLIER	I	I		STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RE	SOURCES - ALAMANCE	, INC			215 COLLEGE STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 657	about the use of any left the facility. In an interview on 01/ Aide #3 indicated that wear a monitoring ala aware of this. She did an elopement risk bed and impaired cognition In an interview on 01/ #8 indicated that the about the because the resident elopement. In an interview on 01/ MDS Coordinator cor behaviors were not pl and there was no use wandering according document. She stated current care plan did elopement risk. She i learned of needed rev department meetings meeting on the units. directly of a change in stated that any nurse point-of-care guides the could initiate an issue In an interview on 01/ acknowledged that the to reflect the lowered #253. She stated that conducted in early Of monitoring alarm was shared her expectation	device that alerted staff if he /08/18 at 12:20 p.m., Nurse t the resident refused to arm and that the nurses were d not consider the resident cause of his limited mobility on. /08/18 at 12:44 p.m., Nurse alarm was discontinued was not at risk for /09/18 at 10:00 a.m., the firmed that wandering resent for Resident #253 e of a monitoring device for to the latest MDS d she was not aware that the not reflect the lowered ndicated that she usually visions by attending the daily and daily stand-up clinical Staff could also notify her in the care plan. She further can update care plans and but only a registered nurse a. /09/18 at 4:30 p.m., the DON e care plan was not updated elopement risk for Resident t an elopement screen	F	657	7		

Facility ID: 923271

If continuation sheet Page 6 of 12

		MEDICAID SERVICES			OMB NO. 0938-
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345337	B. WING		01/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PEAK RE	SOURCES - ALAMANCE	INC		215 COLLEGE STREET GRAHAM, NC 27253	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLE
F 657	Continued From page	9 6	F 65	7	
	that revisions were do keep the plans currer	one in a timely manner to at.			
F 761	Label/Store Drugs an	d Biologicals	F 76	1	2/6/18
SS=E	CFR(s): 483.45(g)(h)	(1)(2)			
	Drugs and biologicals labeled in accordance	of Drugs and Biologicals used in the facility must be with currently accepted			
	professional principle appropriate accessor				
	instructions, and the eapplicable.	expiration date when			
	§483.45(h) Storage o	f Drugs and Biologicals			
	Federal laws, the faci biologicals in locked of	ordance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys.			
	locked, permanently a storage of controlled the Comprehensive E Control Act of 1976 a abuse, except when t package drug distribu	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can			
	by: Based on observatio facility failed to store labeled packaging to	is not met as evidenced n and staff interviews, the 91 tablets and capsules in identify the medication xpiration date in four of five ected.		This Plan of Correction constitute written allegation of compliance for deficiencies cited. However, subr of this Plan of Correction is not an admission that a deficiency exists Plan of Correction is submitted to	or the nission n s. This

Event ID: W4WV11

Facility ID: 923271

If continuation sheet Page 7 of 12

	-	ND HUMAN SERVICES MEDICAID SERVICES				M APPROVE D. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
		345337	B. WING		01	/09/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	ZIP CODE	
				215 COLLEGE STREET		
PEAK RE	SOURCES - ALAMANCE	z, INC		GRAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 761	Continued From pag	0.7	F 76			
1 701		e /	F /0		d by state and	
	Findings included: 1. During an inspect	ion of Station 3 's		requirements establishe federal law.	ed by state and	
		on 01/04/18 at 9:30 a.m., five				
	loose white tablets a	nd one loose colored tablet ttom of the second drawer on		F-761		
	the right-hand side.			1. Medication carts 3	-A. 4. 1-A and 1-B	
				were immediately clear		
	In an interview on 01	/04/18 at 9:30 a.m., Nurse #		pills and unidentified me		
		ne unpackaged medications		medications were remo		
		n. She acknowledged they		per policy on 1/4/18. Ro	-	
	were not labeled or s	stored correctly.		was performed by the fa	•	
	2 During on increase	ion of Ototion 41 a		management staff to de		
	2. During an inspect	1/04/18 at 9:50 a.m., a total		of the deficient practice not cleaning their medic		
		ere found in the bottom of		facility practice. No resi		
		nite tablets, one colored tablet		adversely affected by th		
		s were loose in the second		practice.		
	-	and side. Three white				
	tablets, two colored t	ablets and two partial tablets		2. All licensed nursing		
		d drawer on the right-hand		in-serviced by Staff Dev		
	side.			Coordinator or her desi	<b>o</b> 1 1	
	la en intervieu uith N			cleaning of medication		
		Nurse #6 on 01/04/18 at 9:50 hat had she seen the		removal and destruction unidentified medication		
		e would have thrown them		medication carts. Educa		
		ontainer. Nurse #6 was		completed on 1/9/18		
		the medications after they				
	were retrieved from t	he drawers.		3. An audit tool was	•	
				monitor all medication of	-	
	3. During an inspect			pills and unidentified me		
		on 01/04/18 at 10:05 a.m., a		audits will be conducted		
		and three capsules were		development Coordinat		
		of four drawers. Eighteen ored tablets, one capsule and		designee every shift for one month, and weekly		
		were loose in the second		The results of these au		
		and side. Eight white tablets,		the need for further mo		
	-	s and two capsules were		compliance with the PC	-	
		wer on the right-hand side.		be noted and reviewed		
	Three white tablets, t	three colored tablets and four		Quality Assurance and	Performance	

Facility ID: 923271

If continuation sheet Page 8 of 12

PRINTED: 02/15/2018 FORM APPROVED

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/15/20 <sup>.</sup> MAPPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>′</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345337	B. WING			01/	/09/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	OURCES - ALAMANCE			215	5 COLLEGE STREET		
	JOURCES - ALAMANCE	., 110		GF	RAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 761	Continued From page	e 8	E F	761			
	partial tablets were lo the right-hand side. C	bose in the fourth drawer on One loose white tablet was ver on the left-hand side.			Improvement Committee meeting.		
	10:05 a.m., she indic medications must ha blister packs when th	ve been released from the le drawer was packed full ressed against each other. red discarding the					
	1-B on 01/04/18 at 10 was found loose in th	f Station 1 ' s medication cart D:35 a.m., one white tablet the bottom of the fourth and side and one colored the first drawer on the					
	10:35 a.m., she ident	lurse #7 on 01/04/18 at ified the medications as not scarded them in a secured					
	Director of Nursing as medications discover medication carts were offered that the pills r the pharmacy blister moved against each the pills had unintent when nurses popped administration. She s	/08/18 at 4:00 p.m., the cknowledged that the red on inspection of the e not stored correctly. She may have broken free from packs when they were another in the drawer, or that ionally fallen in the drawers them from the packs during shared her expectation that d in appropriately labeled					
	containers or other particular medication name.	ackaging to include the					
F 812	Food Procurement,S	tore/Prepare/Serve-Sanitary	F 8	312			2/6/18

If continuation sheet Page 9 of 12

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345337	B. WING			01/	09/2018
NAME OF P	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		00/2010
PEAK RE	SOURCES - ALAMANCE	INC			15 COLLEGE STREET		
					GRAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812 SS=E	CFR(s): 483.60(i)(1)(	2)	F	812			
	§483.60(i) Food safet The facility must -	y requirements.					
	state or local authoriti (i) This may include for from local producers, and local laws or regu (ii) This provision doe facilities from using pi gardens, subject to co safe growing and food (iii) This provision doe from consuming food	ed satisfactory by federal, es. bod items obtained directly subject to applicable State ulations. s not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility.					
	serve food in accorda standards for food se This REQUIREMENT by: Based on observatio facility failed label ope freezer, dietary staff f dish washing process a clean ice scoop and machine in the nouris	-			This Plan of Correction constitutes writ allegation of compliance for the deficiencies cited. However, submissio of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law.	n	
	Findings included:				F-812		
	9: 15 AM revealed an transparent bag conta cut cauliflower not lab	walk in freezer on 1/2/18 at opened, half-filled aining food that looked like beled and an opened bag ozen pieces of meat in a			1. The food in the walk-in freezer tha was unlabeled and undated was immediately discarded. The personal for and beverage was removed and placed into the employee break room. The ice	bod d	

Event ID: W4WV11

Facility ID: 923271

If continuation sheet Page 10 of 12

					OMB NO. 0938-
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345337	B. WING		01/09/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
PEAK RE	SOURCES - ALAMANCE	, INC		215 COLLEGE STREET GRAHAM, NC 27253	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLE THE APPROPRIATE DATE
F 812	Continued From page	e 10	F 81	2	
1 012	box labeled Beef Sali dated. 2. Observation on 1/2 staff entered into the with a restaurant labe clear plastic cup with placing the brown ba clean steam table an one of the cups. Die aware and he reques and take it to their bro During an interview w (DM) on 1/2/18 at 9:3 opened bag of food s appropriately. He als be bringing in their pe as no eating or drinki kitchen. He further st their personal food in During an interview w 1/9/18 at 11:00 AM , she had brought in for	2/18 at 9:30 AM revealed kitchen with a brown bag el and 2 cold beverages in a straws. Staff was observed g and beverages on the d sipping beverage from the tary Manager was made sted staff to remove the food eak room. with the Dietary Manager 85 AM, DM indicated that any should be labeled and dated o stated that staff should not ersonal food to the kitchen ng was allowed inside the ated that staff should put		<ul> <li>scoops and holder were im cleaned. The employee that dishes immediately discarce cloth, washed his hands ar gloves. Root cause analysis performed by the dietary medetermined that dietary stat following facility policy. No adversely affected by the dietary staff on labeling and items. All dietary/kitchen st responsible for the proper I dating of food items stored The dietary manager/desig proper labeling and dating daily. The dietary manager dietary staff on proper clean scoops and holders. The dimanager/designee will insp scoops and holders in the I rooms daily to ensure clean daily rounds. Education of to include removing of pers</li> </ul>	at washed the ded the white ad put on is was nanager. It was ff were not residents were deficient will educate all d dating of food taff will be labeling and in the kitchen. ynee will ensure of food items twill educate all ning of ice ietary bect the ice nourishment nliness during f all dietary staff
	personal food should and not brought into 3. Observation of ice room near the nursin at 12:32 PM revealed inside the ice scoop h	machine in the nourishment g station 1 hallway on 1/8/18 d the ice scoop was placed nolder that was not clean.		<ul> <li>beverages in the kitchen at hand hygiene while handlir education will be completed</li> <li>3. An audit tool was deveronitor proper labeling and items, cleanliness of ice sc holders, proper hand hygie</li> </ul>	ng dishes. All d by 2/6/18. eloped to d dating of food poops and ene during the
	that looked like dried Interview with DM on	had brown colored bottom dirt. 1/8/18 at 12:35 PM revealed nd holder were washed by		dish washing process, and food and beverages in the These audits will be condu Dietary Manager or his des 2 weeks, weekly for four w	kitchen area. cted by the signee daily for

Event ID: W4WV11

Facility ID: 923271

If continuation sheet Page 11 of 12

TATEMENT C	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:			. ,	MPLETED
		345337	B. WING			01/09/2018
NAME OF PR	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
PEAK RES	OURCES - ALAMANCE	, INC		215 COLLEGE STREET GRAHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETION DATE
F 812	Continued From page	e 11	F 81	2		
	dietary on a regular b not sure why it was n	asis. He indicated he was ot washed.		monthly for two months these audits will determ further monitoring to en	ine the need for	
	4. During dish washir	ng observation on 1/8/18 at		with the POC. The resu	-	
		aff who was handling clean		be noted and reviewed	in the monthly	
		oves and using a white		Quality Assurance and		
		s placed near the clean e his hands frequently. The		Improvement Committe	e meeting.	
		te the observation too and				
		nove the white colored cloth				
	and wash his hands.	The staff discarded the				
		ut did not wash his hands				
	and use gloves, and task assigned.	he returned to complete the				
	During an interview with the dietary Staff #1 on 1/8/18 at 2:13 PM, staff indicated that he was					
		ed cloth to wipe his wet				
	•	indicated that he had				
	÷	hands and use gloves				
		e task. The staff then went				
		nds and wore gloves. Dishes gh the dish washing cycle.				
	During an interview w	vith the DM on 1/8/18 at 2:15				
		at dietary staff should not be				
		dish washing and should				
	be washing his hands appropriately.	s and use gloves				
	PM, DM stated that it	with DM on 1/9/18 at 1:00 was his expectation that				
		nd hygiene, appropriately d and use break room for				
		le further stated that all ice				
		b holders should be washed				
		the nourishment rooms.				

Facility ID: 923271

If continuation sheet Page 12 of 12