		ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED
		345395	B. WING		C 06/01/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PEAK RE	SOURCES-CHERRYVILL	E		7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ARY STATEMENT OF DEFICIENCIES II ICIENCY MUST BE PRECEDED BY FULL PRE RY OR LSC IDENTIFYING INFORMATION) TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
F 561 SS=D		cited as a result of the on. Event ID #GOID11. (3)(8)	F 56	1	6/27/18
	promote and facilitate through support of re-	right to and the facility must resident self-determination sident choice, including but is specified in paragraphs (f)			
	activities, schedules (waking times), health				
		ident has a right to make s of his or her life in the cant to the resident.			
	with members of the	ident has a right to interact community and participate in both inside and outside the			
	religious, and commu interfere with the righ facility. This REQUIREMENT	ident has a right to tivities, including social, nity activities that do not ts of other residents in the is not met as evidenced			
		ns, record reviews, resident he facility failed to honor		Filing the plan of correction does not constitute that the alleged deficiencies of	did
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
Electroni	cally Signed				06/25/2018

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

					OMB NO. 093			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURV COMPLETED			
		345395	B. WING		С			
	ROVIDER OR SUPPLIER	343395		STREET ADDRESS, CITY, STATE, ZIP	06/01/20)18		
NAME OF P	ROVIDER OR SUPPLIER			7615 DALLAS CHERRYVILLE HIGH				
PEAK RE	SOURCES-CHERRYVILL	E		CHERRYVILLE, NC 28021	IWAT			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COM THE APPROPRIATE	(X5) IPLETIO DATE		
F 561	Continued From page	a 1	F 56	1				
1 001		for eating in his room for 1	F 50		correction is filed			
		nt #34) reviewed for choices.		in fact exist. The plan of of as evidence of the facility	s desire to			
	The findings included	l:		comply with the requirement continue to provide high q				
	Resident #34 was ad	mitted to the facility on		F561				
		ses which included recent		Resident #34 was met wit	h and his			
		ve head trauma (bleed),		preferences have been ho	onored and are			
	hypertension (HTN),	atrial fibrillation, convulsions		clearly documented in the				
	and peripheral vascu	lar disease (PVD).		All nursing staff were edu	-			
				Staff Development Coordi				
		#34s admission Minimum		regarding communication				
	. ,	essment dated 05/16/18 derately cognitively impaired		preferences and the impo allowing resident choice.				
		king, required extensive		follow through with the co				
		sons with most activities of		system in place by the fac				
		I was frequently incontinent		The facility will promote a				
	of bowel and bladder			resident self determination	n of all residents			
				who are cognitively able to				
		434s admission Care Area		This will be accomplished	-			
		ummary for ADL dated		development of a resident	-			
		e was admitted to the facility		interview form which will in				
		alization following a fall with 5/18. He was admitted for		preferences regarding the resident wishes to get out				
		other diagnoses included		as where the resident wo				
		, gastro-esophageal reflux		receive his/ her meals. The				
	disease (GERD), con			developed by the Adminis	trator and will be			
		e assistance of 1-2 persons		completed by 6/26/18 for	-			
		rs and nursing staff to		the Administrative nursing				
	-	a timely manner. Therapy		Social Worker and all resi	dent profiles will			
		lent as ordered by the y is very supportive in the		be updated accordingly. All staff were educated by	the Staff			
		er the family the resident		Development Coordinator				
		placement due to his wife's		regarding the importance				
		ng chemo treatment. He is		resident⊡s choices in all a	-			
	frequently incontinent	t of bowel and bladder and		her life that are significant	to the resident.			
	-	sist with toileting and or		The resident preference in				
		ast every 2 hours and as		completed for new admiss				
	needed. Monitor skir	n integrity with each		quarterly at the care plan	conterence. An			

Facility ID: 923100

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TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE S COMPL	
		345395	B. WING		C 06/01/2018	
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RE	SOURCES-CHERRYVILL	E		7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 561	performed weekly and The resident is at risk previous fall with right generalized weakness deconditioning. Nurs and keep call bell with use call bell at times, and encourages the u- risk for skin impairme mobility and generaliz an antidepressant on and family requested Family was concerne antidepressant at the consulting the family. concerned that he main in the facility. A psych and the family is in ag services to see him. medication and if place antidepressant or oth monthly for recomme Review of Resident # 05/11/18 revealed he assistance for all ADL fall with injury, general physical deconditionin measurable with appr resident. A review of Resident on admission reveale the dining room. An observation and ir and family member at 10:21 AM revealed the	nd nursing skin audits to be d address any issues noted. f or falls related to a t sided subdural hematoma, s and physical ing staff to anticipate needs hin reach. Resident doesn't staff frequently monitors use of the call bell. He is at nt related to decreased zed weakness. He received e day during the look back it to be discontinued. d about who started the previous facility without Family is however ay get depressed with being he consult was completed greement with psyche Pharmacy is to monitor his ced back on an er medication will monitor ndation for reduction. 34s care plan dated was dependent on staff . except eating related to his alized weakness and	F 56	audit tool was developed to monitor the preference interview has been completed, that the resident prefer are communicated via the residen and that the preferences are being honored. The Resident Preference tool will be completed by the Direct Nursing / MDS Coordinators for 25 residents weekly for 8 weeks, ther monthly for 4 months. The need f further audits will be determined b the results of the audits for the prior months. Results of the audits will be review analyzed by the Director of Nursin monthly QAPI meetings. The Director of Nursing is respons implementing the acceptable plan correction.	rences t profile e audit stor of 5% of all or ased on or 6 ved and g at the sible for	

· ,				0.0938-0391
A. BUILD		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
B. WING				C /01/2018
	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1
PREF	IX	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
ed to be ng ng d ir y n. of ir ir	561			
	B. WING	B. WING B. WING 7 7 7 7 7 7 7 7 7 7 7 7 7	sTREET ADDRESS, CITY, STATE, ZIP CODE 7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021 D PREFIX TAG PREFIX TAG F 561 ed to be F 561 g ng d ir y n. n of i to ko	A. BUILDING

Facility ID: 923100

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CENTER	S FOR MEDICARE &	ND HUMAN SERVICES			FORM APPROVE	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C	
		345395	B. WING		06/01/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	SOURCES-CHERRYVILL	E		7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 561	Continued From page preferences and wou	e 4 Id have to look at them.	F 561			
F 641 SS=D	Director of Nursing (E expectation was for re- honored. The DON s not have been gotten dining room to eat his his preference. Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mus resident's status. This REQUIREMENT by: Based on record rev facility failed to accur Data Set (MDS) to re- status for 1 of 1 resid for hospitalization. The findings included Resident #99 was ad 04/04/18 with diagnos diabetes mellitus, ma breast, depressive ep compression fracture resident was discharg 04/22/18. The admission MDS cognitively intact for o	esidents' preferences to be stated Resident #34 should up early and taken to the s breakfast when it was not nents of Assessments. St accurately reflect the T is not met as evidenced iews and staff interviews the ately code the Minimum flect a resident's discharge ent (Resident #99) reviewed	F 641	F641 For Resident #99, the discharge MDS dated 4/24/18 was modified on 6/1/18 reflect that the resident was discharged the community. The MDS Coordinator failed to follow the policy for properly coding assessments. An audit will be completed by the MDS Coordinator for 100% of all residents discharged within the last 60 days to v that discharge location is accurately coded on the discharge MDS assessment. Assessments will be modified as needed. This will be completed by 6/26/18. Education was provided to the Interdisciplinary Care Plan team on 6/22/18 to include MDS Coordinators, Social Services, Activity Director, Dieta Manager, and Therapy Manager by the Director of Nursing/ RN Consultant	d to erify	

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S FOR MEDICARE & I		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
	IDENTIFICATION NUMBER:	· ,		COMPLETED	
				С	
	345395			06/01/2018	
ROVIDER OR SUPPLIER					
OURCES-CHERRYVILL	E				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETI	
Continued From page	9 5	F 64	1		
Worker on 04/22/18 m discharged home with health was to follow for occupational therapy, (NA). There were no issues or concerns up Review of the physicial dated 04/24/18 reveal discharged as stable health. Review of the dischar revealed Resident #9 to an acute hospital. An interview with the 1:52 PM revealed the incorrectly. The MDS should have been coor Resident #99 dischar and home health follo stated it had been coor	evealed the resident was a her daughter and home or physical therapy, nursing and nurse aide equipment needs and no bon discharge. an's discharge summary led the resident was with follow up with home rge MDS dated 04/24/18 9 was coded as discharged MDS nurse on 06/01/18 at discharge was coded a nurse stated the discharge ded as community because ged home with her daughter w up. The MDS nurse ded incorrectly and she		regarding the assessment process the importance of coding the MDS accurately. An audit tool was developed to mon MDS assessments for proper codin discharge locations on the discharg assessment. Audits will be comple the Director of Nursing/ RN Consul 100% of all discharged residents w for 8 weeks, then monthly for 4 mon The need for further audits will be determined based on the results of audits for the prior 6 months. Results of the audits will be reviewed analyzed by the Director of Nursing monthly QAPI meeting. The Director of Nursing is responsi implementing the acceptable plan of correction.	hitor Ig of Ig MDS ted by tant for eekly hths. the ed and I at the ble for	
An interview with the 06/01/18 at 2:50 PM r MDS assessments to the resident's current Quality of Care CFR(s): 483.25 § 483.25 Quality of ca	Director of Nursing on revealed she expected the be coded correctly to reflect status.	F 684	4	6/27/18	
	Continued From page Review of a progress Worker on 04/22/18 r discharged home with health was to follow for occupational therapy, (NA). There were no issues or concerns up Review of the physici dated 04/24/18 revea discharged as stable health. Review of the dischar revealed Resident #9 to an acute hospital. An interview with the 1:52 PM revealed the incorrectly. The MDS should have been coor Resident #99 dischar and home health follo stated it had been coor would correct it imme An interview with the 06/01/18 at 2:50 PM to MDS assessments to the resident's current Quality of Care CFR(s): 483.25 § 483.25 Quality of care is a fu	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: 345395 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 Review of a progress note written by the Social Worker on 04/22/18 revealed the resident was discharged home with her daughter and home health was to follow for physical therapy, occupational therapy, nursing and nurse aide (NA). There were no equipment needs and no issues or concerns upon discharge. Review of the physician's discharge summary dated 04/24/18 revealed the resident was discharged as stable with follow up with home health. Review of the discharge MDS dated 04/24/18 revealed Resident #99 was coded as discharged to an acute hospital. An interview with the MDS nurse on 06/01/18 at 1:52 PM revealed the discharge was coded incorrectly. The MDS nurse stated the discharge should have been coded as community because Resident #99 discharged home with her daughter and home health follow up. The MDS nurse stated it had been coded incorrectly and she would correct it immediately. An interview with the Director of Nursing on 06/01/18 at 2:50 PM revealed she expected the MDS assessments to be coded correctly to reflect the resident's current status. Quality of Care	IDENTIFICATION NUMBER: A BUILDING 345395 B. WING ROVIDER OR SUPPLIER SOURCES-CHERRYVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 5 F 64: Review of a progress note written by the Social Worker on 04/22/18 revealed the resident was discharged home with her daughter and home health was to follow for physical therapy, occupational therapy, nursing and nurse aide (NA). There were no equipment needs and no issues or concerns upon discharge. Review of the physician's discharge summary dated 04/24/18 revealed the resident was discharged as stable with follow up with home health. Review of the discharge MDS dated 04/24/18 revealed Resident #99 was coded as discharged to an acute hospital. An interview with the MDS nurse on 06/01/18 at 1:52 PM revealed the discharge was coded incorrectly. The MDS nurse stated the discharge should have been coded as community because Resident #99 discharged home with her daughter and home health follow up. The MDS nurse stated it had been coded incorrectly and she would correct it immediately. An interview with the Director of Nursing on 06/01/18 at 2:50 PM revealed she expected the MDS assessments to be coded correctly to reflect the resident's current status. F 684 § 483.25 Quality of Care Quality of Care is a fundamental principle that F 684	CORRECTION IDENTIFICATION NUMBER: A BUILDING 345395 B. WING ROWDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7615 DALLAS CHERRYVILLE 7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ON LISC IDENTIFYING INFORMATION) ID PREFIX TAG PREVIDENT FUNCTION NUMBER: Continued From page 5 F 641 regarding the assessment process the importance of coding the MDS discharged home with her daughter and home health was to follow for physical therapy. occupational therapy, nursing and nurse aide (NA). There were no equipment needs and no issues or concerns upon discharge. F 641 Review of the physician's discharge summary dated 04/24/18 revealed the resident was discharged home with her Aughter and home health. F 641 Review of the discharge MDS dated 04/24/18 revealed Resident #99 was coded as discharge to an acute hospital. F 641 Review of the discharge MDS dated 04/24/18 revealed Resident #99 was coded as discharge should have been coded as community because Resident #99 discharged home with her daughter and home health follow up. The MDS nurse stated it had been coded incorrectly and she would correct it immediately. F 684 An interview with the Director of Nursing on 06/01/18 at 2:50 PM revealed she expected the MDS assessments to be coded corectly to reflect the resident's current status. F 684 S 483.25 Cuality of Care CFR(s): 483.25 F 684	

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SUF	938-03 RVEY
	CORRECTION	IDENTIFICATION NUMBER:			COMPLET	
					С	
		345395	B. WING		06/01/2	2018
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		-		7615 DALLAS CHERRYVILLE HIGHWAY		
PEAN NE	SOURCES-CHERRYVILL	E		CHERRYVILLE, NC 28021		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE C	(X5) OMPLETIC DATE
F 684	Continued From page	6	F 68	4		
1 001		treatment and care in		+		
	accordance with profe					
		nensive person-centered				
	care plan, and the res					
	This REQUIREMENT	is not met as evidenced				
	by:					
		iew and staff interviews the		F684		
		e the bowel protocol for 1 of		There were no adverse effects to		
		for unnecessary medication		Resident #18 and he had a bowe		
	use (Resident #18).			failed to follow the system for mo	-	
	The findings included	:		bowel movements that was in pla	•	
				facility.		
		mitted to the facility on		All residents bowel records we		
	11/22/17 with diagnos			reviewed by the Director of Nurs	•	
	hypotension, non-Alz			6/22/18 for the prior 30 days and		
	Parkinson's disease,	and psychotic disorder.		bowel protocol was followed app for residents requiring the bowel		
		and psycholic disorder.		criteria. The process has been of		
	Review of the guarter	ly Minimum Data Set dated		in that the bowel records will be		
	-	sident #18 was severely		daily by each hall nurse and the		
	cognitively impaired a	and required extensive		initiated and followed as necessa	ary. The	
	assistance with toileti	ng.		Director of Nursing/ Nursing Sup		
				will also review the bowel record		
	-	an dated 04/25/18 revealed		morning for the prior day to ensu		
		ong term resident with related psychosis, anxiety		compliance that the resident rece appropriate follow up with Milk of		
	and depressive disor			Magnesium, Dulcolax suppositor		
		ions, placing the resident at		fleets enema as needed.	,	
		ions related to the use of		Licensed Nursing staff were edu		
		he goal was for Resident		the Staff Development Coordinat		
		any discomfort or adverse		6/1/18 regarding the importance		
		the use of psychotropic		following the bowel protocol and		
	medications. The inte	erventions included:		process for monitoring bowel rec administering ordered medication		
		every shift: high fever,		necessary.		
	-	static hypotension, sedation,		An audit tool was developed to n	nonitor	
		fects (such as constipation).		that the bowel protocol is initiated		

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		MEDICAID SERVICES			OMB NO. 0938-	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		с	
		345395	B. WING		06/01/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/01/2010	
		-		7615 DALLAS CHERRYVILLE HIGHWAY		
	SOURCES-CHERRYVILL	E		CHERRYVILLE, NC 28021		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	
F 684	Continued From page	- 7	F 68			
		bowel records from 04/30/18	1 00	movement in 3 days and that the		
		ealed Resident #18 had no		appropriate interventions were		
	-	cumented on 05/15/18,		implemented. Audits will be complete	ed by	
		5/18/18, and 05/19/18 for a		the Nursing Supervisor/ Staff		
	total of 5 days withou	t a bowel movement.		Development Coordinator for 25% o	fall	
	Boviow of the facility	standing orders for bowel		residents weekly for 8 weeks, then monthly for 4 months. The need for		
		to bowel movement in 3		further audits will be determined bas	ed on	
		gnesium, if not effective in 12		the results of the audits for the prior		
	hours give dulcolax s			months.		
	effective in 12 hours	give fleets enema.		Results of the audits will be reviewed		
				analyzed by the Director of Nursing	at the	
		ation Administration from 31/18 revealed Resident #18		monthly QAPI meetings. The Director of Nursing is responsib	lo for	
	had not received any			implementing the acceptable plan of		
	dulcolax suppository,	-		correction.		
		ed on 05/31/18 at 10:15 AM				
		ed she should have started				
	-	r Resident #18 after he went bowel movement but she				
	-	she reviewed the bowel				
		aily but overlooked the five				
		18 did not have a bowel				
	movement document	ed.				
	An interview conducto	ed on 06/11/18 at 12:03 PM				
		ursing revealed it was her				
	expectation for nurse	s to start the bowel protocol				
	for any resident that of					
Г 000	movement in three da	-	F 00		0.00.11	
F 690 SS=D	CFR(s): 483.25(e)(1)	tinence, Catheter, UTI -(3)	F 69	U	6/22/18	
	§483.25(e) Incontiner	nce.				
		cility must ensure that				
	resident who is contir	nent of bladder and bowel on				
	admission receives s	ervices and assistance to				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 07/11/2018 1 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345395	B. WING			06/0) 01/2018
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	OURCES-CHERRYVILL	E			615 DALLAS CHERRYVILLE HIGHWAY HERRYVILLE, NC 28021		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690	condition is or become not possible to mainta §483.25(e)(2)For a re- incontinence, based of comprehensive assess ensure that- (i) A resident who entri- indwelling catheter is resident's clinical con- catheterization was no- (ii) A resident who entri- indwelling catheter or is assessed for remov- as possible unless that demonstrates that cat and (iii) A resident who is receives appropriate to prevent urinary tract in continence to the exter §483.25(e)(3) For a re- incontinence, based of comprehensive assess ensure that a resident receives appropriate to restore as much norm possible. This REQUIREMENT by: Based on observation record review the faci- resident's catheter ba- floor and ensure it wat	unless his or her clinical es such that continence is ain. sident with urinary on the resident's sement, the facility must ers the facility without an not catheterized unless the dition demonstrates that ecessary; ters the facility with an subsequently receives one val of the catheter as soon e resident's clinical condition theterization is necessary; incontinent of bladder treatment and services to nefections and to restore ent possible. esident with fecal on the resident's sement, the facility must t who is incontinent of bowel treatment and services to nal bowel function as	F	590	F690 Facility staff identified the issue with th catheter bag on 5/19/18 at approximat 2:00 PM and the catheter bag was pla- in an appropriate privacy bag and tubir was no longer touching the ground wit prompting by the surveyor. Resident #	ely ced ng nout	

Facility ID: 923100

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CENTERS FOR MEDICARE & MEDICAR & MEDICARD SERVICES OMB NO. 0938-0391 STRUMENT OF DEFICIENCIANE AND LERVICES 0 (2) MULTIPLE CONSTRUCTION		-	ID HUMAN SERVICES				FORM	APPROVED	
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An observation of Resident #38 on 05/29/18 at 1:02 PM while Resident #38 was leaving the main			•						
1:02 PM while Resident #38 was leaving the main									
1:02 PM while Resident #38 was leaving the main		An observation of Re-	sident #38 on 05/29/18 at						
dining room after his lunch meal revealed the			U						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2018 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345395	B. WING				01/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RE	SOURCES-CHERRYVILL	E			7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 690 F 761 SS=E	resident's catheter bag ground while he mobil and the catheter bag white cloth bag of unk During an interview w 06/01/18 at 11:01 AM on 5/29/18 and noted catheter bag was in a did not know who had but reported the catheter been in a pillowcase of further reported "they where the privacy bag An interview with Nur AM revealed she had Resident #38 on 05/2 seeing his catheter bag pillowcase. She furth #38's catheter bag an the ground and that th not be in anything oth privacy bag. On 06/01/18 at 11:32 the Director of Nursin expectation that prop- be followed and that of touch or drag the floo stored in an appropria on the wheelchair. Label/Store Drugs an CFR(s): 483.45(g) Labeling of Drugs and biologicals	g to continue to drag the lized along with the tubing continued to be stored in the known type. With Nurse Aide #4 on revealed she had worked that Resident #38's pillowcase. She stated she d initially put it in a pillowcase eter bag should not have or touching the ground. She probably did not know gs were". se #3 on 06/01/18 at 11:12 worked on the hall and with 9/18 but could not recall ag on the floor or in a white er reported that Resident to tubing should not touch he catheter bag itself should ler than an appropriate AM during an Interview with g it was revealed it was her er infection control policies catheter bags and tubing not r and that catheter bags be ate privacy bag when hung d Biologicals		690			6/15/18

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345395	B. WING				01/2018
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
PEAK RE	SOURCES-CHERRYVILL	E			7615 DALLAS CHERRYVILLE HIGHWAY		
,				0	CHERRYVILLE, NC 28021		
(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 APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	professional principle appropriate accessory instructions, and the e applicable. §483.45(h) Storage o §483.45(h)(1) In acco Federal laws, the faci biologicals in locked o temperature controls, personnel to have acc §483.45(h)(2) The fac locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 an abuse, except when t package drug distribut quantity stored is min be readily detected. This REQUIREMENT by: Based on observation facility failed to discar 1 of 1 medication root carts, the 600 hall me The findings included Observation of the me at 12:13 PM revealed that were expired, in t use.	s, and include the y and cautionary expiration date when f Drugs and Biologicals rdance with State and lity must store all drugs and compartments under proper and permit only authorized cess to the keys. cility must provide separately affixed compartments for drugs listed in Schedule II of orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can f is not met as evidenced ins and staff interviews, the d expired medications from ms and 1 of 3 medication dication cart. : edication room on 06/01/18 the following medications the cabinet and available for	F	761	F761 All expired medications were removed from the medication room and medicat cart immediately. There have been no adverse effects to any residents. Pharmacy staff failed to remove the medications per facility policy on 5/10/ Licensed Nursing staff have been educated by the Staff Development Coordinator on 6/1/18 regarding the importance of clearly marking the expiration dates, not administering expired medications, and properly disposing of expired medications. An audit tool was developed to monito	18.	

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	S FOR MEDICARE &	MEDICAID SERVICES		PLE CONSTRUCTION	(X3) DATE	0. 0938-039		
	CORRECTION	IDENTIFICATION NUMBER:	. ,	A. BUILDING				
						С		
		345395	B. WING		06/	01/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE			
PEAK RESOURCES-CHERRYVILLE				7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF O PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TI DEFICIENC'		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE		
F 761	Continued From page	e 12	F 76	51				
F 761	 Continued From page 12 (1) bottle of Deep Sea Premium Saline Nasal Moisturizing Spray - unopened that expired 04/2017 (2) boxes of Famotidine 10 mg tablets - unopened with 30 tablets each and expired 05/2018 (1) opened bottle of Nature's Blend Super B Complex with C - approximately 75 capsules in the bottle that expired 05/2018 (3) bottles of Zinc 50 mg containing 100 tablets each unopened and expired on 02/2018 (4) bottles of Vitamin B12 250 mg tablets containing 120 tablets each unopened and expired on 05/2018 An interview on 06/01/18 at 12:34 PM with the Supervising RN revealed the medications should have been removed from the cabinet and discarded. Observation of the 500 hall cart found no expired medications. Observation of the 600 hall cart on 06/01/18 at 1:35 PM revealed the following medications that were expired, on the cart and available for use. (1) bottle of Vitamin B 12 350 mcg opened bottle with approximately 75 tablets in the bottle 			that expired medications ar medication stock is rotated completed weekly by the S Development Coordinator/ Supervisor. Pharmacy will monitor medications rooms medication carts monthly. Results of the audits will be analyzed by the Staff Deve Coordinator at the monthly meetings. The Director of Nursing is r implementing the acceptab correction.	. Audits will be taff Nursing continue to and e reviewed and lopment QAPI responsible for			
	 and expired on 05/20 2. (1) bottle Cerovit bottle with 10 tablets on 05/2018 3. (1) box of Famot 							
	expired on 05/2018 4. (1) bottle of Zant	ac 150 mg tablets opened the bottle of 30 tablets and						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2018 MAPPROVED D. 0938-0391
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345395	B. WING				C 01/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	OURCES-CHERRYVILLI	E			615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 761	Continued From page	13	F	761			
		/18 at 1:55 PM with the 600 e medications should have le medication cart and					
	Nursing (DON) reveal	/18 with the Director of ed she expected all expired noved from the medication					
F 791 SS=D	Routine/Emergency D CFR(s): 483.55(b)(1)-		F	791			6/27/18
		ces tresidents in obtaining mergency dental care.					
	§483.55(b) Nursing Fa The facility-	acilities.					
	outside resource, in a of this part, the follow the needs of each res	ices (to the extent covered and					
	assist the resident- (i) In making appointn	ansportation to and from the					
	residents with lost or o dental services. If a re	omptly, within 3 days, refer damaged dentures for ferral does not occur within st provide documentation of					

Facility ID: 923100

If continuation sheet Page 14 of 19

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 07/11/2018 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345395	B. WING				C 01/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	SOURCES-CHERRYVILL	E			615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 791	and drink adequately services and the exter led to the delay; §483.55(b)(4) Must hat circumstances when the dentures is the facility charge a resident for dentures determined policy to be the facility §483.55(b)(5) Must as eligible and wish to par reimbursement of der medical expense und This REQUIREMENT by: Based on record revif facility failed to make for a resident having to 3 residents reviewed (Resident #11). The findings included Resident #11 was addr 11/21/17 with diagnos anxiety, depression, a pulmonary disease. Review of the quarter dated 04/10/18 reveal	re the resident could still eat while awaiting dental nuating circumstances that ave a policy identifying those he loss or damage of 's responsibility and may not the loss or damage of in accordance with facility y's responsibility; and esist residents who are articipate to apply for tal services as an incurred er the State plan. is not met as evidenced ew and staff interviews the a referral for dental services rouble eating meals for 1 of for dental services : mitted to the facility on tes of Alzheimer's disease, and chronic obstructive ly Minimum Data Set (MDS) led Resident #11 was y impaired. Review of the 1 11/28/17 revealed	F	791	F791 Resident #11 was seen by the facility dentist on 5/4/2018 for complete oral exam to include assessment for dentur Consult states there is a 50/50 rate of success for the upper and the odds on lower are very, very low. The prior approval process was initiated. Reside has had a weight gain since admission Nursing staff failed to follow facility der policy. An audit will be completed by 6/26/18 f all long-term residents to validate that thave received appropriate dental servit to include the oral exam and evaluation for dentures/ denture adjustments as appropriate and referrals completed if necessary. Licensed Nursing staff have been	the ent ital for chey ces	
	moderately cognitively admission MDS dated Resident #11 had no	y impaired. Review of the I 11/28/17 revealed natural teeth or tooth			for dentures/ denture adjustments as appropriate and referrals completed if necessary.	1	

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		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	E CONSTRUCTION		O. 0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,			· · ·	PLETED
							С
		345395	B. WING			06	6/01/2018
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RE	E	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021					
(X4) ID PREFIX TAG	(EACH DEFICIENC	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 791	revealed: Resident # approached this nurs "She is having issues chew her food and w ones." Per nursing di at this time. Dietary in Review of Resident # revealed no dental re It further revealed no during 11/2017 or 12. An interview conduct with the Unit Manage son came to her shor the facility and told he chew her food becau with her dentures. Sh to downgrade her die not assess her dentu stated if a resident di referral should have I services and a speed make a referral for Re service. An interview conduct with the Registered D resident was having I expectation for a spe referral to be made to chewing problem. Sh downgrade the diet b referral for follow up.	11's family member se regarding diet. Son stated, s with her teeth and can't e can't afford to get her new et change to mechanical soft nformed. 411's medical record ferral in 11/2017 or 12/2017. speech therapy referral /2017. ed on 05/31/18 at 10:35 AM er revealed Resident #11's rtly after she was admitted to er Resident #11 could not use she was having problems ne stated she wrote an order et to mechanical soft but did res. The Unit Manager et was downgraded a been made for dental ch evaluation but she did not esident #11 for either ed on 06/01/18 at 10:30 AM Dietician (RD) revealed if a problems chewing it was her eech therapy and dental o determine the cause of the es stated the nurse could out should always make a	F	791	importance of obtaining routine and emergency dental care to include pror referrals for lost or damaged dentures completing a speech and dental referr when a diet is downgraded. An audit tool was developed to monito that residents have received routine dental care, that resident s dentures in good condition and fit appropriately and if a diet has been downgraded, th the appropriate dental and speech referrals have been made. Audits will completed by the Nursing Supervisor/ Staff Development Coordinator for 25' all residents weekly for 8 weeks, then monthly for 4 months. The need for further audits will be determined bases the results of the audits for the prior 6 months. Results of the audits will be reviewed analyzed by the Director of Nursing at monthly QAPI meetings. The Director of Nursing is responsible implementing the acceptable plan of correction.	and al or are , at be % of d on and the	
	 with the Unit Manages son came to her short the facility and told her chew her food becaut with her dentures. Short to downgrade her die not assess her dentures stated if a resident di referral should have to services and a speed make a referral for Reservice. An interview conduct with the Registered E resident was having performent to be made to chewing problem. Short downgrade the diet b referral for follow up. An interview conduct with the Director of N expectation for a referent to be made to chewing for a referent to be made to chewing the diet b referral for follow up. 	er revealed Resident #11's rtly after she was admitted to er Resident #11 could not se she was having problems he stated she wrote an order et to mechanical soft but did ires. The Unit Manager et was downgraded a been made for dental ch evaluation but she did not esident #11 for either ed on 06/01/18 at 10:30 AM Dietician (RD) revealed if a problems chewing it was her eech therapy and dental o determine the cause of the is stated the nurse could out should always make a			completed by the Nursing Supervisor/ Staff Development Coordinator for 25 all residents weekly for 8 weeks, then monthly for 4 months. The need for further audits will be determined based the results of the audits for the prior 6 months. Results of the audits will be reviewed analyzed by the Director of Nursing at monthly QAPI meetings. The Director of Nursing is responsible implementing the acceptable plan of	% of d on and the	

Facility ID: 923100

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DATE SURVEY		
	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED		
					с		
		345395	B. WING		06/01/2018		
NAME OF PI	ROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE			
	SOURCES-CHERRYVILL	F		7615 DALLAS CHERRYVILLE HIGHWAY			
	SOURCES-CHERRY VIEL	. _		CHERRYVILLE, NC 28021			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETIC		
F 791	Continued From page	e 16	F 79	1			
	-	er dentures. She stated it					
		e nurse to downgrade the					
		ollow up with dental or					
	speech therapy servi	ces should always be					
F 867	initiated. QAPI/QAA Improvem	ent Activities	F 86	7	6/27/18		
F 007 SS=D	CFR(s): 483.75(g)(2)		F OU	1	0/27/10		
00-D	(g)(_)	('')					
	§483.75(g) Quality as	ssessment and assurance.					
	§483.75(g)(2) The qu	ality assessment and					
	assurance committee						
		ement appropriate plans of tified quality deficiencies;					
		is not met as evidenced					
		iews and staff interviews the		F867			
		ssment and Assurance		Education was provided to the			
	Committee failed to n	•		Interdisciplinary Care Plan team on			
		tor the interventions the		6/25/18 to include MDS Coordinators			
	committee put into pla	-		Social Services, Activity Director, Die	-		
		of 06/15/17. This was for as originally cited in June of		Manager, and Therapy Manager by the Director of Nursing regarding the	ne		
	-	quently recited on the current		assessment process and the importa	nce		
	recertification and co			of coding the MDS accurately.			
		federal surveys of record		The facility failed to follow the QAPI p			
		facility's inability to sustain		to review issues from past surveys ar			
	and effective Quality	Assurance Program.		evaluate current plans for effectivene Education was provided to the facility			
	The findings included	:		Quality Assurance & Performance			
				Improvement (QAPI) committee mem	bers		
	This tag were cross r	eferenced to:		to include the Medical Director, Staff			
	F 641: Accuracy of a	ssessments: Based on		Development Coordinator, Treatment Nurse, MDS Coordinators, and Dieta			
		taff interviews the facility		Manager by the Administrator and Dieta			
		ode the Minimum Data Set to		of Nursing on 6/25/18 regarding the C			
	reflect a resident's dis	scharge status for 1 of 1		committee and program. The educat			
	resident reviewed for	hospitalization (Resident		includes the objectives of the QAPI			

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STATEMENT	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	ECONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OI	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED			
245205		D WING	С				
		345395			06/01/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
PEAK RE	SOURCES-CHERRYVILL	E		7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETIO		
F 867	Continued From page	e 17	F 867				
	 #99). During the recertifica facility was cited at F code the admission N of motion (Resident # Preadmission Screer (Resident #27) for 2 of An interview conduct 06/01/18 at 3:07 PM of the plan of correcti monitoring for F 641 corrected the problem 	tion survey of 06/15/17 the 641 for failing to accurately Minimum Data Set for range #15) and Level II hing and Resident Review of 14 sampled residents. ed with the Administrator on revealed they completed all		program including to identify and revises from past surveys and evaluate current plan for its effectiveness and change the plan as needed, the pur- of the QAPI program to provide a m for resident care and safety issues to resolved, and how the committee monitors issues and follows up with unresolved issues that have been identified. The QA policy was reviewed by the Administrator. The policy states that facility shall develop, implement, an maintain an ongoing program desig monitor and evaluate the quality of resident care, pursue methods to im care quality, and to resolve identified problems. No changes to the policy necessary. The QA Self Evaluation audit tool monitors the QA committee and its functions and monitors if the commi- has a current plan in place, if the committee identifies who is respons- oversee the plan, if the plan is worki it is not working have changes been into place to improve, if the outcome- measurable, if the project has been successful, and if the plan can be considered resolved. The audit tool will be completed by the sub-committee to include the Direct Nursing, Staff Development Coordir and MDS Coordinators twice a mon 6 months. Ongoing use of the Self-Evaluation tool will be determin	ate the pose eans o be t the d ned to prove d were ttee ible to ing, if put e is the or of nator, th for		

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TATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	O. 0938-039 E SURVEY IPLETED	
			A. BUILDIN	G		C	
		345395	B. WING		_ 00	5/01/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
PEAK RE	SOURCES-CHERRYVILL	E		7615 DALLAS CHERRYVIL CHERRYVILLE, NC 280			
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 867	Continued From page	e 18	F 8	67 will be reviewed ar Director of Nursing meetings and char recommendations necessary.	nd analyzed by the at the monthly QAPI nges or will be discussed as rsing is responsible for		

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