	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	Y
		345337	B. WING		02/07/2019	
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CO		13
			215	COLLEGE STREET		
PEAK RE	SOURCES - ALAMANC	E, INC	GR	AHAM, NC 27253		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE DA	PLETION
E 000	Initial Comments		E 000			
	conducted on 2/4/19 was found in compli	ecertification survey was 9 through 2/7/19. The facility ance with the requirement gency Preparedness. Event ID				
F 656 SS=E		Comprehensive Care Plan	F 656		3/7/19	Э
	implement a compre- care plan for each ri- resident rights set for §483.10(c)(3), that i objectives and time medical, nursing, ar- needs that are ident assessment. The co- describe the followin (i) The services that or maintain the resid physical, mental, ar- required under §483 (ii) Any services that under §483.24, §48 provided due to the under §483.10, inclu- treatment under §48 (iii) Any specialized rehabilitative service provide as a result of recommendations. I findings of the PAS/ rationale in the resid	are to be furnished to attain dent's highest practicable ad psychosocial well-being as 3.24, §483.25 or §483.40; and t would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 33.10(c)(6). services or specialized es the nursing facility will of PASARR f a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the iative(s)-				

**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.

03/01/2019

TATEMENT (	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) D.	NO. 0938-039 ATE SURVEY DMPLETED
		0.45007	B. WING	_			
		345337	B. WING				02/07/2019
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE  15 COLLEGE STREET		
PEAK RES	SOURCES - ALAMANCE	, INC			GRAHAM, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 656	future discharge. Fac whether the resident's community was asse- local contact agencie entities, for this purper (C) Discharge plans i plan, as appropriate, requirements set forth section. This REQUIREMENT by: Based on staff interv facility failed to developerson-centered activi individualized goals a cognitively impaired r assistance with activiti #66, #67 and #99). The findings included 1. Resident #30 was 6/19/12. The diagnos impairment, commun retardation. Review of the activity 11/21/18, revealed re activities with interest trips, shopping, outdo movies, plays/theatre The quarterly Minimu	eference and potential for ilities must document s desire to return to the ssed and any referrals to s and/or other appropriate ose. In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced iews and record reviews, the op a comprehensive vity care plan that included and approaches for 5 of 5 residents that needed ties (Resident #30, #55, I: admitted to the facility on es included cognitive ication deficit and mental r assessment dated sident preference in group t in exercise/sports, music, por activities, current events,	F	656	<ul> <li>F-656</li> <li>1. For Residents # 30, #55, #66, and #99 did not suffer any adverse of from the failure to develop a comprehensive activity care plan. Their comprehensive person-center and resident specific care plans wer immediately changed to reflect individualized goals and approaches cognitively impaired residents that n assistance with activities on 2/14/19 the Activity Director.</li> <li>2. For residents having the potent be affected by the same deficient pr all residents comprehensive person-centered and resident specific activity care plans were reviewed fo individualized goals and approaches the Activity Director on 2/14/19. All resident activity care plans were amount of the set of the activity care plans were amount of the activit</li></ul>	effects ed re s for eeded by ial to actice fic r s by	
	impaired and needed Review of the activity	assistance with activities.			by the Activity Director on 2/14/19 to reflect individualized goals and approaches for cognitively impaired residents that needed assistance wi	)	

Event ID: FHM511

Facility ID: 923271

If continuation sheet Page 2 of 32

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	· · ·	DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	С	OMPLETED
		345337	B. WING			02/07/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P 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	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From page	e 2	F 65	6		
		t in exercise/sports, music,		activities.		
		oor activities, current events,				
	movies, plays/theatre	and dining out.		3.3. The Administrator e Activity Director and Acti		
	Review of the care pl	an dated 1/10/19, identified		3/1/19 on reviewing com		
		lent #30 at times would		resident specific person-		
		alking loudly, demands		plans upon admission, q		
		nxious/aggravated. The goal uld sit through an activity		during annual assessme significant change in sta		
	without any outburst			Person-centered care pl		
	-	offer 1:1 assistance to		resident changes/progre		
		resident calm. Praise		and or discontinued whe		
		nt has sat through an activity nd stop activities if resident		This review for accuracy following the MDS calen		
	seems to get aggrava	-		assessments by the Acti		
	-	n 2/7/19 at 11:33 AM, the				
		IDS) Nurse stated the II departments to ensure		4. An audit was devel	oped that includes	
		vere resident specific /person		assessment reference d		
		eds with measurable goals		the activity care plan is o		
	and approaches. The			the needs of the residen		
		d annually to represent gress and discontinued		accuracy of care plans, assessments will be revi		
		esident #30's activity care		the IDT (Interdisciplinary		
	•	irse she stated the resident's		includes the Director of I	Nursing, Social	
	-	dard plan for all residents		Worker, Staff Developm		
	-	n-center or resident specific sessment or activities of		MDS nurses, Social Wor Dietician, in the Clinical		
	interest.			for four weeks and then	•	
				months, and/or until a p		
		n 2/7/19 at 11:45 AM, the		compliance is achieved.		
		the expectation was to e plans for current resident		be noted and reviewed i Quality Assurance Comr		
		ble goals and approaches to			intee meeting.	
	include resident spec	ific areas and person				
		lans should be updated accuracy of service needed				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	
		345337	B. WING			02	07/2019
NAME OF P	ROVIDER OR SUPPLIER	1		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 656	plans revealed the go resident assessments measurable goals or 2. Resident #55 was 12/23/15. The diagno communication defici Review of the activity revealed resident pre activities with interest spiritual, religious act animals/pets, current movies, poetry and ra included 1:1 activity, activities, talk-orienta interaction activities, activities, talk-orienta interaction activities. The quarterly Minimu 12/24/18, coded Resi impaired and needed Review of the resider included a "problem" required extensive as to memory related to resident would be abl complete a simple ac week. The approache resident to participate as watching others da socializing, eat out, cu dance/music, modify residents' ability and activities, remind and during activities and s	abals did not reflect the s nor did they have approaches. admitted to the facility on ses included cognitive t and dementia. assessment dated 10/4/18, ference in small group in crafts, art, music, ivities, gardening/plants, events, drawing/painting, adio. Focused activities creative/expressive outings, intellectually religious/relaxation tion activities and social m Data Set (MDS) dated dent #55's cognition was assistance with activities. at's care plan dated 1/10/19, that specified Resident #55 sistance in activities related dementia. The goal included e to remember and tivity task three times a es included encourage e in activities of interest such ance, watching television,	F	656			

Facility ID: 923271

If continuation sheet Page 4 of 32

		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345337	B. WING			02	/07/2019
NAME OF PF	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From page	2 4	F	656			
	Minimum Data Set (Mexpectation was for a resident care plans we center to resident need and approaches. The updated quarterly and resident changes/prowhen appropriate. We care plan was review stated the resident's of plan for all residents a or resident specific basessment or activite. During an interview of Administrator stated the review the entire care issues with measurate include resident specific basessment or activite plans revealed the go resident assessments and/or discontinued. I plans revealed the go resident assessments are plans revealed the go resident assessments measurable goals or a 3. Resident #66 was 2/20/13. The resident regroup activities and 1 sports, music, reading activities, gardening/pevents, drawing/paint	d annually to represent gress and discontinued hen Resident #55's activity ed with the MDS nurse she care plan was a standard and it was not person-center ased on resident ies of interest. In 2/7/19 at 11:45 AM, the he expectation was to plans for current resident ble goals and approaches to ific areas and person ans should be updated accuracy of service needed Review of the activities care bals did not reflect the s nor did they have approaches. admitted to the facility on 's diagnoses included tion deficit and dementia.					

Facility ID: 923271

If continuation sheet Page 5 of 32

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/18/2019 1 APPROVED 0. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE	
		345337	B. WING		_	02/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			2	15 COLLEGE STREET			
PEAK RES	SOURCES - ALAMANCE,	INC	G	RAHAM, NC 27253			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	activities, religious/rel talk-orientation activiti activities. The annual Minimum 1/19/19, coded Resid- impaired and needed Review of the residen included a "problem" required extensive as to memory related to resident would be abl complete a simple activities resident to participate as watching others da socializing, eat out, cu dance/music, modify a residents ' ability and activities, remind and during activities and s to encourage resident During an interview of Minimum Data Set (M expectation was for a resident care plans w center to resident need and approaches. The updated quarterly and resident changes/prog when appropriate. Wh	expressive activities, itellectually stimulating axation activities, ies and social interaction Data Set (MDS) dated ent #66's cognition was assistance with activities. It's care plan dated 1/25/19, that specified Resident #66 sistance in activities related dementia. The goal included e to remember and tivity task three times a es included encourage in activities of interest such ance, watching television, urrent events and approaches according to response to levels during assist resident to/from and implify and breakdown task t participation in activities. In 2/7/19 at 11:33 AM, the IDS) Nurse stated the II departments to ensure ere resident specific /person eds with measurable goals care plan should be annually to represent gress and discontinued nen Resident #55's activity	F 656		DEFICIENCY)		
	stated the resident's of	ed with the MDS nurse she care plan was a standard and it was not person-center ased on resident					

Facility ID: 923271

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		345337	B. WING			02	/07/2019
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	assessment or activiti During an interview of Administrator stated to review the entire care issues with measurable include resident spect centered. The care pl quarterly/annually for and/or discontinued. If plans revealed the go resident assessments measurable goals or a 4. Resident #67 was 11/15/16. The resider cognitive communicat The quarterly Minimu 11/24/18, specified Re impaired and needed Review of the activity 12/31/18, revealed re group activities with in spiritual, religious activit animals/pets, current movies, poetry, wood radio. Focused activit creative/expressive a intellectually stimulati religious/relaxation activities and social in Review of the resider included a "problem" required extensive as to memory related to resident would be abl	ies of interest. In 2/7/19 at 11:45 AM, the he expectation was to a plans for current resident ble goals and approaches to ific areas and person ans should be updated accuracy of service needed Review of the activities care hals did not reflect the a nor did they have approaches. admitted to the facility on ht's diagnoses included tion deficit and dementia. Im Data Set (MDS) dated esident #67's cognition was assistance with activities. assessment dated sident preference in small herest in crafts, art, music, ivities, gardening/plants, events, drawing/painting, working, word games and ies included 1:1 activity, ctivities, talk-orientation heraction activities. at's care plan dated 1/28/19, that specified Resident #67 sistance in activities related dementia. The goal included	F	656			

Facility ID: 923271

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STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE CONSTRUCTION       (X3) DATE SURV         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING       COMPLETER				ID HUMAN SERVICES MEDICAID SERVICES	-	CENTER
345337 B. WING	COMPLETED		· ·	(X1) PROVIDER/SUPPLIER/CLIA	OF DEFICIENCIES	STATEMENT (
02/07/20	02/07/2019	۱G	В.	345337		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	ET ADDRESS, CITY, STATE, ZIP CODE	ST			ROVIDER OR SUPPLIER	NAME OF P
PEAK RESOURCES - ALAMANCE, INC       215 COLLEGE STREET         GRAHAM, NC 27253				, INC	SOURCES - ALAMANCE	PEAK RE
	(EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE	REFIX		Y MUST BE PRECEDED BY FULL	(EACH DEFICIENC	PREFIX
F 656       Continued From page 7       F 656         week. The approaches included encourage resident to participate in activities of interest such as watching others dance, watching television, socializing, ead out, current events and dance/music, modify approaches according to residents' ability and response to levels during activities, remind and assist resident to/from and during activities, remind and assist resident to/from and during activities, remind and assist resident to/from and during activities and simplify and breakdown task to encourage resident participation in activities.         During an interview on 2/7/19 at 11:33 AM, the Minimum Data Set (MDS) Nurse stated the expectation was for all departments to ensure resident to resident specific /person center to resident needs with measurable goals and approaches. The care plan should be updated quareity and annually to represent resident thanges/progress and discontinued when appropriate. When Resident #55° activity care plan was reviewed with the MDS nurse she stated the residents and it was not person-center or resident specific based on resident assessment or activities of interest.         During an interview on 2/7/19 at 11:45 AM, the Administrator stated the expectation was to review the entire care plans for current resident issues with measurable goals and approaches to include resident specific based and approaches to include resident specific areas and approaches.         5. Resident #99 was ad		F 656		es included encourage e in activities of interest such ance, watching television, urrent events and approaches according to response to levels during assist resident to/from and simplify and breakdown task t participation in activities. In 2/7/19 at 11:33 AM, the MDS) Nurse stated the all departments to ensure were resident specific /person eds with measurable goals e care plan should be d annually to represent gress and discontinued hen Resident #55's activity ed with the MDS nurse she care plan was a standard and it was not person-center ased on resident ies of interest. In 2/7/19 at 11:45 AM, the the expectation was to e plans for current resident ole goals and approaches to ific areas and person lans should be updated accuracy of service needed Review of the activities care oals did not reflect the s nor did they have approaches. admitted to the facility on	week. The approacher resident to participate as watching others da socializing, eat out, c dance/music, modify residents' ability and activities, remind and during activities and s to encourage residen During an interview o Minimum Data Set (N expectation was for a resident care plans w center to resident nee and approaches. The updated quarterly and resident changes/pro when appropriate. Wi care plan was review stated the resident's o plan for all residents a or resident specific ba assessment or activiti During an interview o Administrator stated th review the entire care issues with measurate include resident spec centered. The care pl quarterly/annually for and/or discontinued. plans revealed the go resident assessments measurable goals or 5. Resident #99 was	F 656

	-	ID HUMAN SERVICES MEDICAID SERVICES				F	FORM APPROVED B NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		345337	B. WING				02/07/2019
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
PEAK RE	SOURCES - ALAMANCE	INC			COLLEGE STREET AHAM, NC 27253		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 656	communication deficii quarterly Minimum Da 1/28/19, coded Resid impaired and needed Review of the activity revealed resident pre activities and 1:1 with card/board/games mu activities, gardening/p events, drawing/paint and coloring. Focused activity, creative/expri- outings, intellectually religious/relaxation ac activities and social in Review of the resider included a "problem" required extensive as Resident enjoys binge included resident wou complete a simple ac week. The approache resident to participate as watching others da socializing, eat out, cu dance/music, modify residents' ability and during activities and s to encourage residen During an interview o Minimum Data Set (M expectation was for a resident care plans w	t and dementia. The ata Set (MDS) dated ent #99's cognition was assistance with activities. assessment dated 1/7/19, ference in small group interest in usic, spiritual, religious blants, animals/pets, current ing, movies, plays/theatre d activities included 1:1 essive activities, community stimulating activities, ctivities, talk-orientation nteraction activities. at's care plan dated 1/28/19, that specified Resident #99 sistance in activities. b and music. The goal uld be able to remember and tivity task three times a es included encourage in activities of interest such ance, watching television, urrent events and approaches according to response to levels during assist resident to/from and simplify and breakdown task t participation in activities. n 2/7/19 at 11:33 AM, the IDS) Nurse stated the II departments to ensure ere resident specific /person eds with measurable goals	F	556			

Facility ID: 923271

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		ND HUMAN SERVICES			PRINTED: 03/18/20 FORM APPROVE
TATEMENT (	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345337	B. WING		02/07/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	
	SOURCES - ALAMANCE			215 COLLEGE STREET	
	SOURCES - ALAMANCE	., INC		GRAHAM, NC 27253	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 656	Continued From page	e 9	Fe	556	
F 679 SS=E	resident changes/pro- when appropriate. W care plan was review stated the resident's plan for all residents or resident specific b assessment or activit During an interview of Administrator stated review the entire care issues with measural include resident spec centered. The care p quarterly/annually for and/or discontinued. plans revealed the go resident assessment measurable goals or Activities Meet Intere CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The fa- the comprehensive a and the preferences program to support re activities, both facility individual activities a designed to meet the physical, mental, and each resident, encour and interaction in the	ties of interest. on 2/7/19 at 11:45 AM, the the expectation was to e plans for current resident ble goals and approaches to cific areas and person lans should be updated r accuracy of service needed Review of the activities care bals did not reflect the s nor did they have approaches. st/Needs Each Resident cility must provide, based on ssessment and care plan of each resident, an ongoing esidents in their choice of <i>interests of and support the</i> a psychosocial well-being of raging both independence	Fé	579	3/7/19
		ons, staff interview and cility failed to provide an		F-679	

Facility ID: 923271

If continuation sheet Page 10 of 32

		MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		345337	B. WING		02/03	7/2019
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 679	Continued From page	e 10	F 67	79		
	met the individual interest the quality of life for 5 residents reviewed for #55, #66, #67 and #9 The findings included 1. Resident #30 was 6/19/12 and resided of The resident's diagno impairment, commun retardation. Resident #30 was co Minimum Data Set (N having impaired cogr assistance with activity 11/21/18, revealed re activities with interest	admitted to the facility on on the facility's 200 hallway. oses included cognitive ication deficit and mental ded on the quarterly /IDS) dated 11/22/18, as hition and he needed tites. v assessment dated esident preference in group t in exercise/sports, music, por activities, current events,		<ol> <li>The facility Activity Diimmediately gathered resident with the facility Activity Diimmediately gathered resident with the factor of the calendary according to the calendary at the designated times are offered to all residents according to the calendary at the designated times are offered to all residents according to the calendary at the designated times are offered to all residents according to the calendary at the designated times are offered to all residents according to the affected by the same di All residents had review of person-centered preference. Activity Director on 2/14/19 residents were adversely a ongoing program to support their choice of activities, be sponsored group and individual activities and independent designated to meet the intropychosocial well-being of encouraging both independing interaction in the communication in the communication in the communication.</li> </ol>	dents #30, #55, k them to the tivity programs will be followed ad locations and cording to their the potential to eficient practice : f ces by the 9. No other affected. An ort residents in oth facilities vidualized activities, erest of and tal, and f each resident, dence and	
	would disrupt activitie demanding things, or anxious/aggravated. would sit through an once weekly without approaches included resident to help keep resident when reside without an outburst a seems to get aggrava	e resident would at times es by talking loudly, becoming The goal included resident activity without any outburst any outburst. The offer 1:1 assistance to resident calm. Praise nt has sat through an activity nd stop activities if resident		3. The Administrator edu Activity Director and Activi 3/1/19 about the importance activities for all residents a both employees to monito attendance and record wh attend according to their in The Activity Director will po calendar monthly in the ha in residents rooms and wil activities to meet the need residents. The attendance recorded in an attendance	ty Assistant on ce of daily and educated or both the ich residents nterest choices. ost the activity allway and and I offer varied s of all will be	

Facility ID: 923271

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STATEMENT (	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	OMB NO. (X3) DATE S	
ND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COMPL	ETED.
		345337	B. WING		02/0	7/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
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 ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 679	Continued From page	e 11	F 67	9		
	at 10:00 AM he repor music, sports, bingo,	ted being interested in church and fun stuff.		electronic health record acc residents names and dates		
	the following activities 02/04/19: 10:00 AM coffee club visits (no designated Observations of Resi AM and at 3:00 PM re hallway activity room and not participating scheduled at these tin Review of the facility' the following activities 02/05/19: 10:00 AM coffee club 2:00 PM kingdom Ha name (no description Observations of Resi AM, 10:30 AM, 2:00 F was in the 200 hallwa in any activity and no	4, 3:00 PM Bingo and in room time frame) dent #30 on 2/4/19 at 10:00 evealed he was in the 200 not engaged in any activity in the activities that were mes on the activity calendar. s activity calendar revealed s were scheduled for 4, 10:30 AM fancy fingers, II and 3:00 PM volunteer's		4. An audit tool was dever include dates, times, location participation and to compar- calendar to actual activity of ensure accuracy of activity attendance according to the choices, the Administrator wa activities weekly for four wee then bi-weekly for two month a pattern of compliance is a results will be noted and rew monthly Quality Assurance meeting.	on and resident e activity ccurring. To calendars and e resident vill audit 15 eks, 10 and hs, and/or until ichieved. The viewed in the	
	calendar. During an interview o Nursing Assistant (N/ facility's 200 hallway, for staff to get all resi- activities and to take activity and/or the ma schedule activities. N taken any of the resio any of the scheduled	n 2/6/19 at 11:27 AM, A) #2, who worked on the stated the expectation was dents up, ready for the them to the scheduled ain dining room if there were A #2 indicated she had not dents from the 200 hall to				

Facility ID: 923271

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 03/18/2019 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		_	(X3) DATE	
		345337	B. WING			02/	07/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY,	STATE, ZIP CODE		
PEAK RES	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	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 679	Continued From page	2 12	F 67	79			
	who worked on the fa	n 2/6/19 at 11:29 AM, NA#3, cility's 200 hallway, stated					
		ere bathed and dressed they ne activity room on the 200					
		then to other activities.					
		taken residents to the					
		was uncertain whether the d she had not taken any					
	residents to any other						
		ted the activities staff was					
		the activity and NAs were with taking residents to the					
	activities when availa	-					
		n 2/6/19 at 11:40 AM, NA					
		e facility's 200 hallway, were groomed and dressed					
		ere to be taken to the 200					
		to watch television. NA #4					
		vities staff were expected to					
		d activities and the NA staff ist with taking residents to					
	the activities when we						
		n 2/6/19 at 11:43 AM, NA e facility's 200 hallway,					
		n of the NA staff was to					
		is the residents on the 200 sed and ready for activities.					
	NA #5 further explained	-					
	expected to take resid	dents to the 200 hallway					
		) AM, for the scheduled					
		d aides were to assist with ner activities in the facility					
	-	5 stated the activity staff					
	were expected to run	the activities that was					
	scheduled.						

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/18/2019 APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE COMF		
		345337	B. WING				02/	07/2019
NAME OF P	PROVIDER OR SUPPLIER			S	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 LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE		(X5) COMPLETION DATE
F 679	During an interview of Activities Director (AE unaware the activities hallway on 2/4/19 and scheduled and reside were not encouraged the scheduled activities facility's 200 hallway. not have a system in cognitively impaired re #30, received or atter added the expectation assist and bring resid AD reviewed several activities and stated th does not incorporate impairments. The AD for her to document q participation and prog not have a system in records and documer During an interview of Administrator stated th activities staff to run th planned. In addition, a encourage resident pot taking residents to the facility's activities cale revealed the schedule always address the ne dementia or cognitive review of the activities insufficient document participation was inco- more. The Administra	n 2/6/19 at 11:07 AM, the D) indicated she was a scheduled for the 200 d 2/5/19 did not occur as ents on the 200-hall area or offered participation in es that took place off the She further stated she did place to ensure the esidents, including Resident nded activities. The AD n was for the nurse aides to ents to the activities program residents with cognitive stated the expectation was juarterly on resident gress. The AD stated she did place to ensure participation ntation were current. n 2/7/19 at 8:17 AM, the the expectation was for the he activities program as all staff was expected to articipation and assist with e activities. Review of the endar with the administrator ed daily activities did not eeds of residents with e impairments. Additional, s progress notes revealed	F	679				

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 03/18/2019 DRM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		345337	B. WING				02/07/2019	
NAME OF PI	ROVIDER OR SUPPLIER	1	-	s	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 LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 679	12/23/15 and resided The resident's diagon communication defici #55's quarterly Minim 12/24/18, coded the r impaired and needed Review of the resider included a "problem" required extensive as to memory related to resident would be ab complete a simple ac week. The approache resident to participate as watching others da socializing, eat out, c dance/music, modify residents' ability and activities, remind and during activities and s to encourage residen During an interview w at 10:05 AM the residen music, flowers, art an Review of the facility' the following activities 02/04/19: 10:00 AM coffee club visits (no designated Observations of Resi AM and at 3:00 PM re hallway activity room and not participating	admitted to the facility on on the facility's 200 hallway. Dess included cognitive t and dementia. Resident hum Data Set (MDS) dated resident's cognition as assistance with activities. It's care plan dated 1/10/19, that specified Resident #55 asistance in activities related dementia. The goal included le to remember and stivity task three times a es included encourage in activities of interest such ance, watching television, urrent events and approaches according to response to levels during assist resident to/from and simplify and breakdown task t participation in activities. with Resident #55 on 2/4/19 dent reported interest in ad dancing. s activity calendar revealed s were scheduled for b, 3:00 PM Bingo and in room	F	679				

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CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	): 03/18/2019 / APPROVED ). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345337	B. WING		_	02/	07/2019
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	Continued From page	2 15	F 679				
	the following activities 02/05/19: 10:00 AM coffee club 2:00 PM kingdom Hal name (no description) Observations of Resid AM, 10:30 AM, 2:00 F was in the 200 hallwa in any activity and not that were scheduled a calendar. During an interview of Nursing Assistant (NA facility's 200 hallway, for staff to get all resid activities and to take f activities and to take f activity and/or the ma schedule activities. No taken any of the resid any of the scheduled scheduled to take plat During an interview of who worked on the fa once the residents we were to be taken to th hallway for coffee and NA#3 stated she had activity room, but she activity took place and residents to any other scheduled. NA #3 sta responsible for doing	, 10:30 AM fancy fingers, I and 3:00 PM volunteer's ). dent #55 on 2/5/19 at 10:00 PM and 3:00 PM revealed he y activity room not engaged t participating in the activities at these times on the activity n 2/6/19 at 11:27 AM, A) #2, who worked on the stated the expectation was dents up, ready for the them to the scheduled in dining room if there were A #2 indicated she had not ents from the 200 hall to activities that were ce off the 200 hallway. n 2/6/19 at 11:29 AM, NA#3, cility's 200 hallway, stated ere bathed and dressed they he activity room on the 200 d then to other activities. taken residents to the was uncertain whether the d she had not taken any activities that were ted the activities staff was the activity and NAs were					
	activities when availal	with taking residents to the ble.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/18/2019 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		345337	B. WING		_	02/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
			2	15 COLLEGE STREET			
PEAKRE	SOURCES - ALAMANCE,	, INC	G	RAHAM, NC 27253			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	Continued From page	9 16	F 679				
	<ul> <li>#4, who worked on the stated once residents in the morning they whallway activity room further stated the scheduled were expected to assist the activities when were activities when were activities when were activities when were activity room by 10:00 coffee club activity and taking residents to oth when available. NA # were expected to run scheduled.</li> <li>During an interview of Activities Director (AE unaware the activities birector (AE unaware the activities hallway on 2/4/19 and scheduled and reside were not encouraged the scheduled activities facility's 200 hallway. Not have a system in cognitively impaired matching residents and bring residents and bresidents and bresidents and bre</li></ul>	n 2/6/19 at 11:43 AM, NA e facility's 200 hallway, n of the NA staff was to gs the residents on the 200 ased and ready for activities. ed the NA staff was dents to the 200 hallway 0 AM, for the scheduled id aides were to assist with her activities in the facility 5 stated the activity staff the activities that was n 2/6/19 at 11:07 AM, the 0) indicated she was a scheduled for the 200 d 2/5/19 did not occur as nts on the 200 hall area or offered participation in es that took place off the She further stated she did					

Facility ID: 923271

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,		E CONSTRUCTION	(X3) DATE		
		345337	B. WING			02/	07/2019
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 679	activities and stated the does not incorporate impairments. The AD for her to document of participation and prog- not have a system in records and documer During an interview of Administrator stated the activities staff to run the planned. In addition, a encourage resident phataking residents to the facility's activities called revealed the scheduled always address the nudementia or cognitive review of the activities insufficient document participation was inco- more. The Administration 3. Resident #66 was a 2/20/13 and resided of The resident's diagno- communication deficit Minimum Data Set (M Resident #66's cogniti assistance with activities included a "problem" required extensive as to memory related to resident would be abli	he current activities program residents with cognitive stated the expectation was uarterly on resident gress. The AD stated she did place to ensure participation nation were current. In 2/7/19 at 8:17 AM, the he expectation was for the he activities program as all staff was expected to articipation and assist with e activities. Review of the endar with the administrator ed daily activities did not eeds of residents with impairments. Additional, s progress notes revealed ation of resident ities staff to document and document quarterly. admitted to the facility on on the facility's 200 hallway. uses included cognitive t and dementia. The annual IDS) dated 1/19/19, coded tion as impaired and needed ties.	F	679			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE		
		345337	B. WING			02/	07/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 01	
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 679	resident to participate as watching others da socializing, eat out, cu dance/music, modify residents' ability and activities, remind and during activities and s to encourage residen During an interview w at 10:00 AM, he repor church, writing and w Review of the facility's the following activities 02/04/19: 10:00 AM coffee club visits (no designated Observations of Resid AM and at 3:00 PM re hallway activity room and not participating is scheduled at these tim Review of the facility's the following activities 02/05/19: 10:00 AM coffee club 2:00 PM kingdom Hal name (no description Observations of Resid AM, 10:30 AM, 2:00 F was in the 200 hallwa in any activity and not	es included encourage en activities of interest such ance, watching television, urrent events and approaches according to response to levels during assist resident to/from and simplify and breakdown task t participation in activities. with Resident #66 on 2/4/19 rted interest in music, oodwork. s activity calendar revealed s were scheduled for , 3:00 PM Bingo and in room time frame). dent #66 on 2/4/19 at 10:00 evealed he was in the 200 not engaged in any activity n the activities that were mes on the activity calendar. s activity calendar revealed s were scheduled for , 10:30 AM fancy fingers, II and 3:00 PM volunteer's	F	679			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	): 03/18/2019 APPROVED 0. 0938-0391
STATEMENT OF AND PLAN OF C	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE	
		345337	B. WING			_	02/	07/2019
NAME OF PRO	VIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PEAK RESC	OURCES - ALAMANCE,	INC			15 COLLEGE STREET RAHAM, NC 27253			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	K	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679 C	Continued From page	19	F	679				
Nfificaastas EvovrhNaarsrna E#siihfipvtt E#	Aursing Assistant (NA acility's 200 hallway, ; or staff to get all resic activities and to take t activities and to take t activity and/or the mai achedule activities. N/ aken any of the resid- any of the scheduled a acheduled to take place outing an interview or who worked on the fac- bonce the residents we were to be taken to the allway for coffee and NA#3 stated she had activity room, but she activity took place and esidents to any other activities when available outing an interview or 4, who worked on the atted once residents in the morning they we hallway activity room fu- urther stated the activity for vide the scheduled were expected to assis the activities when we outing an interview or f5, who worked on the	ce off the 200 hallway. n 2/6/19 at 11:29 AM, NA#3, cility's 200 hallway, stated re bathed and dressed they e activity room on the 200 then to other activities. taken residents to the was uncertain whether the d she had not taken any activities that were ted the activities staff was the activity and NAs were with taking residents to the ble. n 2/6/19 at 11:40 AM, NA e facility's 200 hallway, were groomed and dressed ere to be taken to the 200 to watch television. NA #4 vities staff were expected to activities and the NA staff st with taking residents to						

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	S FOR MEDICARE &					10. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · /	TE SURVEY MPLETED
		345337	B. WING		0	2/07/2019
NAME OF F	ROVIDER OR SUPPLIER		5	TREET ADDRESS, CITY, STATE, ZIP CODE		
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 679	ensure in the morning hallway were up, dree NA #5 further explain expected to take resi- activity room by 10:00 coffee club activity ar taking residents to ot when available. NA # were expected to run scheduled. During an interview of Activities Director (AE unaware the activities hallway on 2/4/19 and scheduled and reside were not encouraged the scheduled activiti facility's 200 hallway. not have a system in cognitively impaired r #66, received or atter added the expectatio assist and bring resid AD reviewed several activities and stated t does not incorporate impairments. The AD for her to document of participation and prog not have a system in records and document During an interview of Administrator stated the activities staff to run to planned. In addition,	gs the residents on the 200 seed and ready for activities. ed the NA staff was dents to the 200 hallway 0 AM, for the scheduled hd aides were to assist with her activities in the facility 5 stated the activity staff the activities that was a 2/6/19 at 11:07 AM, the D) indicated she was a scheduled for the 200 d 2/5/19 did not occur as ents on the 200-hall area l or offered participation in es that took place off the She further stated she did place to ensure the residents, including Resident hded activities. The AD n was for the nurse aides to lents to the activities. The months of the scheduled he current activities program residents with cognitive stated the expectation was quarterly on resident gress. The AD stated she did place to ensure participation	F 679			

Facility ID: 923271

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345337	B. WING			02	/07/2019	
NAME OF P	ROVIDER OR SUPPLIER			s	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 PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 679	facility's activities cale revealed the schedule always address the m dementia or cognitive review of the activities insufficient documents participation was inco more. The Administra would be for the activ resident participation 4. Resident #67 was a 11/15/16 and resided The resident's diagno communication deficit quarterly Minimum Da 11/24/18, coded Resid impaired and needed Review of the residen included a "problem" required extensive as to memory related to resident would be abl complete a simple active week. The approache resident to participate as watching others da socializing, eat out, cu dance/music, modify residents' ability and activities, remind and during activities and s to encourage resident Review of the facility's the following activities 02/04/19:	endar with the administrator ed daily activities did not eeds of residents with impairments. Additional, s progress notes revealed ation of resident mplete for at least a year or tor stated the expectation ities staff to document and document quarterly. admitted to the facility on on the facility's 200 hallway. ses included cognitive t and dementia. The ata Set (MDS) dated dent #67's cognition as assistance with activities. At's care plan dated 1/28/19, that specified Resident #67 sistance in activities related dementia. The goal included e to remember and tivity task three times a as included encourage in activities of interest such ance, watching television, urrent events and approaches according to response to levels during assist resident to/from and simplify and breakdown task t participation in activities.	F	679				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/18/2019 MAPPROVED ). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	ECONSTRUCTION		(X3) DATE	
		345337	B. WING		_	02/	07/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	•	
PEAK RES	SOURCES - ALAMANCE,	INC		215 COLLEGE STREET GRAHAM, NC 27253			
		ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 679	Continued From page	22	F 679				
	visits (no designated t						
	AM and at 3:00 PM re hallway activity room and not participating i	dent #67 on 2/4/19 at 10:00 evealed he was in the 200 not engaged in any activity n the activities that were nes on the activity calendar.					
	the following activities 02/05/19: 10:00 AM coffee club,	, 10:30 AM fancy fingers, I and 3:00 PM volunteer's					
	AM, 10:30 AM, 2:00 F was in the 200 hallwa in any activity and not	dent #67 on 2/5/19 at 10:00 PM and 3:00 PM revealed he y activity room not engaged participating in the activities at these times on the activity					
	facility's 200 hallway, for staff to get all resid activities and to take to activity and/or the ma schedule activities. Na taken any of the resid any of the scheduled	<ul> <li>A) #2, who worked on the stated the expectation was dents up, ready for the hem to the scheduled in dining room if there were A #2 indicated she had not ents from the 200 hall to</li> </ul>					
	who worked on the fa once the residents we were to be taken to th	n 2/6/19 at 11:29 AM, NA#3, cility's 200 hallway, stated ere bathed and dressed they e activity room on the 200 I then to other activities. taken residents to the					

Facility ID: 923271

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/18/2019 APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	ECONSTRUCTION		(X3) DATE	
		345337	B. WING		_	02/	07/2019
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S	TATE, 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	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	activity took place and residents to any other scheduled. NA #3 sta responsible for doing responsible to assist activities when availal During an interview of #4, who worked on th stated once residents in the morning they w hallway activity room further stated the activity provide the scheduled were expected to assist the activities when we During an interview of #5, who worked on th stated the expectation ensure in the morning hallway were up, dres NA #5 further explaine expected to take resid activity room by 10:00 coffee club activity and taking residents to oth when available. NA # were expected to run scheduled. During an interview of Activities Director (AE unaware the activities hallway on 2/4/19 and scheduled and reside were not encouraged	was uncertain whether the d she had not taken any activities that were ted the activities staff was the activity and NAs were with taking residents to the ble. In 2/6/19 at 11:40 AM, NA e facility's 200 hallway, were groomed and dressed ere to be taken to the 200 to watch television. NA #4 wities staff were expected to d activities and the NA staff ist with taking residents to e can. In 2/6/19 at 11:43 AM, NA e facility's 200 hallway, n of the NA staff was to gs the residents on the 200 used and ready for activities. ed the NA staff was dents to the 200 hallway 0 AM, for the scheduled d aides were to assist with her activities in the facility 5 stated the activity staff the activities that was	F 679				

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D SERVICES				OM	B NO. 0938-0391
FICATION NUMBER:	· /		CONSTRUCTION		DATE SURVEY COMPLETED
345337	B. WING				02/07/2019
		STF	REET ADDRESS, CITY, STATE, ZIP COD	DE	
		GR	•		
PRECEDED BY FULL	ID PREFI TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
Insure the including Resident ities. The AD the nurse aides to a activities. The fifthe scheduled the scheduled the scheduled the scheduled the activities program with cognitive expectation was in resident a AD stated she did insure participation recurrent. It 8:17 AM, the ation was for the as program as as expected to an and assist with as Review of the the administrator ctivities did not esidents with ents. Additional, as notes revealed isident r at least a year or the expectation to document ment quarterly. It so the facility on lity's 200 hallway. It is a context of the administrator ctivities and the administrator ctivities did not esident as a set to a context as a set to a conte	F	679			
		345337     B. WING       345337     B. WING       RECEDED BY FULL PREFICIENCIES RECEDED BY FULL PREFICIENCIES RECEDED BY FULL TAG     ID PREFICIENCIES RECEDED BY FULL PREFICIENCIES       re stated she did onsure the including Resident ities. The AD the nurse aides to e activities. The f the scheduled t activities program with cognitive e expectation was n resident e AD stated she did onsure participation re current.       at 8:17 AM, the tation was for the es program as as expected to n and assist with s. Review of the the administrator ctivities did not esidents with ents. Additional, a notes revealed esident r at least a year or the expectation to document ment quarterly.       o the facility on lity's 200 hallway. ded cognitive ientia. The IDS) dated cognition as	345337       B. WING         215       GR         PREFICIENCIES       ID         PRECEDED BY FULL       PREFIX         YING INFORMATION)       PREFIX         TAG       F 679         er stated she did       F 679         f the scheduled       t activities program         with cognitive       e expectation was         n resident       e AD stated she did         ensure participation       re current.         at 8:17 AM, the       tation was for the         es program as       as expected to         n and assist with       s. Review of the         the administrator       ctivities did not         esidents with       ents. Additional,         s notes revealed       esident         r at least a year or       the expectation         the document       ment quarterly.         o the facility on       lity's 200 hallway.         ded cognitive       entia. The         IDS) dated       cognition as	345337     B. WING       235237     STREET ADDRESS, CITY, STATE, ZIP COL 215 COLLEGE STREET GRAHAM, NC 27253       EDEFICIENCIES     ID PREVIDENT       PREVIDENTIAL VING INFORMATION)     PREVIDENTIAL PREFX TAG       PREVIDENTIAL PREFX     PROVIDENTS PLAN OF CC GROSS-REFERENCED TO THE DEFICIENCY)       er stated she did unsure the including Resident ities. The AD the nurse aides to e activities. The f the scheduled t activities program with cognitive e expectation was n resident e AD stated she did unsure participation re current.       t 8:17 AM, the tation was for the ess program as as expected to n and assist with s. Review of the the administrator ctivities did not usidents with ments. Additional, a notes revealed sident r at least a year or the expectation to document ment quarterly.       o the facility on lity's 200 hallway. Jed cognitive entia. The IDS) dated cognition as	345337     B. WING       345337     STREET ADDRESS, CITY, STATE, ZIP CODE       215 COLLEGE STREET     GRAHAM, NC 27253       CECEDED BY FULL     PEERX       TAG     CRONSERTE ACTION SHOULD BE       VING INFORMATION)     PEERX       TAG     CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY     PEERX       TAG     CROSS-REFERENCED TO THE APPROPRIATE       DEFICIENCY     DEFICIENCY)

Facility ID: 923271

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345337	B. WING			02	/07/2019
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RES	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 PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 679			F	679	9		
	included a "problem" required extensive as Resident enjoys bing goal included residen remember and compl three times a week. T encourage resident to interest such as watc television, socializing dance/music, modify residents' ability and activities, remind and during activities and s to encourage residen Review of the facility! the following activities 02/04/19: 10:00 AM coffee club visits (no designated Observations of Resid AM and at 3:00 PM re hallway activity room	b and music. The care plan t would be able to ete a simple activity task The approaches included o participate in activities of hing others dance, watching , eat out, current events and approaches according to response to levels during assist resident to/from and simplify and breakdown task t participation in activities. s activity calendar revealed s were scheduled for , 3:00 PM Bingo and in room					
	Review of the facility <sup>1</sup> the following activities 02/05/19: 10:00 AM coffee club 2:00 PM kingdom Ha name (no description	, 10:30 AM fancy fingers, ll and 3:00 PM volunteer's ).					
	AM, 10:30 AM, 2:00 F	dent #99 on 2/5/19 at 10:00 PM and 3:00 PM revealed he ly activity room not engaged					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 03/18/2019 APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	
		345337	B. WING		_	02/	07/2019
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
PEAK RES	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 PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 679	that were scheduled a calendar. During an interview of Nursing Assistant (NA facility's 200 hallway, for staff to get all resid activities and to take fa activities and to take fa activity and/or the ma schedule activities. N taken any of the resid any of the scheduled scheduled to take pla During an interview of who worked on the fa once the residents we were to be taken to th hallway for coffee and NA#3 stated she had activity room, but she activity took place and residents to any other scheduled. NA #3 sta responsible for doing responsible to assist activities when availad During an interview of #4, who worked on th stated once residents in the morning they w hallway activity room	t participating in the activities at these times on the activity n 2/6/19 at 11:27 AM, A) #2, who worked on the stated the expectation was dents up, ready for the them to the scheduled in dining room if there were A #2 indicated she had not ents from the 200 hall to activities that were ce off the 200 hallway. n 2/6/19 at 11:29 AM, NA#3, cility's 200 hallway, stated ere bathed and dressed they the activity room on the 200 d then to other activities. taken residents to the was uncertain whether the d she had not taken any activities that were ted the activities staff was the activity and NAs were with taking residents to the	F 679		DEFICIENCY)		
	· ·	d activities and the NA staff ist with taking residents to e can.					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/18/2019 MAPPROVED D. 0938-0391	
STATEMENT O	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345337	B. WING			02	/07/2019	
NAME OF P	ROVIDER OR SUPPLIER		•	Ş	STREET ADDRESS, CITY, STATE, ZIP CODE			
		INC		2	215 COLLEGE STREET			
PEAK KES	SOURCES - ALAMANCE	, INC			GRAHAM, NC 27253			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 679	<ul> <li>#5, who worked on the stated the expectation ensure in the morning hallway were up, dress NA #5 further explain expected to take reside activity room by 10:00 coffee club activity and taking residents to oth when available. NA # were expected to run scheduled.</li> <li>During an interview of Activities Director (AE unaware the activities hallway on 2/4/19 and scheduled and reside were not encouraged the scheduled activities facility's 200 hallway. not have a system in cognitively impaired r #99, received or atter added the expectation assist and bring reside AD reviewed several activities and stated t does not incorporate impairments. The AD for her to document of participation and prognot have a system in records and documer</li> </ul>	n 2/6/19 at 11:43 AM, NA he facility's 200 hallway, in of the NA staff was to gs the residents on the 200 seed and ready for activities. He has taff was dents to the 200 hallway DAM, for the scheduled he addes were to assist with ther activities in the facility 5 stated the activity staff the activities that was n 2/6/19 at 11:07 AM, the D) indicated she was a scheduled for the 200 d 2/5/19 did not occur as ents on the 200-hall area or offered participation in the sthat took place off the She further stated she did place to ensure the esidents, including Resident inded activities. The AD in was for the nurse aides to ients to the activities program residents with cognitive stated the expectation was juarterly on resident gress. The AD stated she did place to ensure participation intation were current. n 2/7/19 at 8:17 AM, the the expectation was for the	F	679				
	Administrator stated t							

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CENTER		ND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
		345337	B. WING		02/07/2019
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CO	DDE
PEAK RES	SOURCES - ALAMANCE	, INC		COLLEGE STREET AHAM, 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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETIC HE APPROPRIATE DATE
F 679	encourage resident p taking residents to th	all staff was expected to articipation and assist with e activities. Review of the	F 679		
	revealed the schedul always address the n dementia or cognitive review of the activitie insufficient document participation was inco more. The Administra would be for the activ resident participation	omplete for at least a year or ator stated the expectation vities staff to document and document quarterly.			
F 690 SS=D	CFR(s): 483.25(e)(1) §483.25(e) Incontine §483.25(e)(1) The far resident who is contin	nce. cility must ensure that nent of bladder and bowel on	F 690		3/7/19
	maintain continence	ervices and assistance to unless his or her clinical les such that continence is ain.			
	ensure that-				
	indwelling catheter is resident's clinical con catheterization was n (ii) A resident who en	not catheterized unless the dition demonstrates that			
	is assessed for remo as possible unless th	val of the catheter as soon e resident's clinical condition theterization is necessary;			

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STATEMENT	S FOR MEDICARE & OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DA	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		345337				02/07/2019		
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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 690	<ul> <li>(iii) A resident who is receives appropriate prevent urinary tract is continence to the extension of the extension o</li></ul>	incontinent of bladder treatment and services to infections and to restore ent possible. esident with fecal on the resident's ssment, the facility must it who is incontinent of bowel treatment and services to nal bowel function as T is not met as evidenced ons, staff interviews and acility failed to keep a heter drainage bag from 1 of 1 sampled residents nary catheter (Resident l: mitted on 12/23/15. The included urinary retention. Im Data Set (MDS) dated desident #55 had cognitive uired total assistance with	F	690	<ul> <li>F-690</li> <li>1. For Resident #55, did not suffer adverse effects from her catheter touching the floor. The facility Charge Nurse #2 immediately removed the catheter bag from touching the floor catheter bag was secured to the bear frame without touching the floor.</li> <li>2. For residents having the potent be affected by the same deficient pr all residents with indwelling catheter were evaluated to see if their catheter were touching the floor. This was conducted by the Director of Nursing Staff Development Coordinator 0n 2 No other residents were identified or affected.</li> <li>3. The Staff Development Nurse and Director of Nursing conducted 100% education to Licensed Nurses and Certified Nursing Assistants regardin catheter bag not being placed on to</li> </ul>	ial to actice rs g and 2/6/19.		

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			000			NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G	· · ·	ATE SURVEY
		345337	B. WING			)2/07/2019
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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 690	and document and re adverse side effects. pain w/urination, urge cramps/spasms, low malaise, nausea, von the bladder, chills, fey concentrated urine, b unexplained change is to physician. During a continuous of from 8:10 AM to 10:3 lying in bed sleep with position on the floor. was detached from the drainage bag was no Several staff entered the roommate. Staff of drainage bag that wa 02/06/19 at 10:38 AM picked the drainage to reposition the bag on During an interview o #2 was asked what the drainage bag and she should be secured an expectation would be	ns as ordered and evaluate port effectiveness and any Assess for UTI (burning, ency, frequency, bladder back pain, flank pain, niting, pain/tenderness over ver, foul odor of urine, lood in urine, confusion, in mental status) and report observation on 02/06/19 8 AM, Resident #55 was in the bed was in the lowest The urinary drainage bag he bed lying on the floor. The t secured to Resident #55. the room to provide care for did not check Resident #55's is lying on the floor. On I Nurse #2 enter room and bag off the floor and	F 69	<ul> <li>floor at any time and secur and below the residents bl licensed nurse or CNA who LOA, vacation or PRN stat educated upon returning to assignments.</li> <li>4. To ensure accuracy of placement not being on the audit tool was created that whether the catheter bag is floor. The Director of Nursi will audit 100% of the resid with an indwelling catheter for 2 weeks and then week 2 weeks and then every sh 4 weeks. The results will b Monthly QAPI meeting to e need for additional interven pattern of compliance is act.</li> </ul>	adder. Any o is either on tus will be o their of catheter bag e floor, a daily : includes s touching the ing or designee dent population daily each shift kly each shift for nift bi-weekly for e brought to our evaluate the ntions or a	
	Director of Nursing st the drainage bag sho floor. The bed should level to ensure the dr resident leg and/or be and unit manager sho	n 2/6/19 at 11:35 AM, the ated the expectation was for uld not to be lying on the be positioned at proper ainage bag was secured to ed. The nurse, charge nurse buld be checking to make er drainage bags were				

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 03/18/2019 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		345337	B. WING			02/07/2019
NAME OF PI	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, S	TATE, ZIP CODE	
PEAK RESOURCES - ALAMANCE, INC				215 COLLEGE STREET GRAHAM, NC 27253		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
F 690	Continued From page	31	F 69			
	secured properly and					
	During an interview o Manager stated the e and nursing to check anchoring of the drair secured either to resi During an interview o Administrator stated t nursing to ensure the secured properly and	n 2/6/19 at 2:30 PM, Nurse xpectation was for the aides proper positioning and hage bag to ensure it was dent or bed. n 2/7/19 at 8:17 AM, the he expectation was for				
	1					

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