	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP		(X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		345229	B. WING		C 04/03/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/00/2010
				1101 NORTH MORGAN STREET	
PEAK RE	SOURCES - SHELBY			SHELBY, NC 28150	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 558 SS=D	CFR(s): 483.10(e)(3) §483.10(e)(3) The rig	odations Needs/Preferences ht to reside and receive	F 55	8	4/20/19
	other residents.	sident needs and			
	Based on resident in record review, the fac choices for 2 of 5 san	terview, staff interviews, and ility failed to honor the npled residents reviewed for		F558 Reasonable Accommodations Needs/Preferences	
	showers she wanted Resident #10's choice he wanted weekly and	3's choice for the number of weekly was not honored and e for the number of showers d for the number of times he alking was not honored.		Resident #10 had no adverse effects w regard to not being ambulated daily. Resident #10 has been receiving restorative as recommended. Resident #3 had no adverse effects with regard to	
	The findings included	:		not being showered per schedule. Resident #3 has had showers as noted the Point of Care records, the resident	on
	12/31/18. His diagno	admitted to the facility on ses included heart failure, llation, dermatitis, muscle		was discharged on 4/9/19.	
		um Data Set dated 01/07/19		All Other and Measures in place:	
	assessed him with int mood issues or behave extensive assistance coded as not having of back period. Resider	act cognition, having no viors, and requiring with bathing. Walking was occurred during the look at #10 was coded for		The restorative schedule has been reviewed and revised on April 12, 2019 the Restorative Nurse. This review clarified how often residents are to rece restorative services.	ive
	restorative ambulation needed during walkin	erapy. eveloped on 02/15/19 for n for him to be assisted as g related to a right above e goal was to ambulate 200		Restorative aides re-educated regarding reporting residents who refuse and/or didn t receive their restorative services Training will be conducted by Restorativ Nurse. Education will be completed by April 12, 2019.	s. /e
	feet with one person a	assistance using a rolling		The shower/bath schedule reviewed an	d (X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

04/23/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER PEAK RESOURCES - SHELBY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TREGULATORY OR LSC IDENTIFYING INFORMATION)			A. BUILDING B. WING	E CONSTRUCTION	FORM OMB NO (X3) DATE COMP (04/	LETED
F 558	Continued From page	1	TAG F 558	DEFICIENCY)		
	walker and stand by a assistance. The care the number of times p with assistance. During initial tour, on a Resident #10 was inte observed to have an a and a prosthesis local interview, Resident #1 the restorative service included assisting him walking. On 04/02/19 at 2:55 F caring for Resident #1 stated that she norma aide but was sometim work. She stated that restorative aide over t pulled to the floor to c further stated that Res over the weekend. SI #10 was able to apply Review of the restorat no specific number of scheduled to walk. Do provided revealed that restorative aervices as *In February 2019, he 02/15/19, 02/17/19, 00 02/22/19 and 02/24/19 14 days. *In March 2019, he wa 03/03/19, 03/04/19, 03	essistance/care giver plan was not specific as to er week he should walk 04/02/19 at 9:20 AM, erviewed. Resident #10 was amputation of his left leg ted at bedside. During the 10 stated he did not receive as he wanted daily which a with his prosthetic leg and 20 M the nurse aide (NA #1) 0 was interviewed. NA #1 Ily worked as a restorative es pulled to the floor to a she was scheduled to be a he past weekend but was over as a nurse aide. She sident #10 was not walked he also stated that Resident to the prosthesis himself. The prosthesis himself. The documentation revealed times Resident #10 was bocumentation of services t from the start of a services on 02/15/19 sident #10 received walking is follows:		 revise by Director of Nursing and/or designee. Schedule completed and update on April 8, 2019. Shower schewill be reviewed with residents upon admission. Nurses and aides re-educated regard reporting residents who refuse and/or didn treceive their shower. Training be conducted by Staff Development Coordinator and/or designee. Educate will be completed by April 10, 2019. Monitoring: An audit utilizing the Point of Carr Compliance Report which determines staff compliance with completing restorative services. This was initiate April 5, 2019. The audit will be compl weekly by Restorative Nurse 25% of a random sample residents for 2 weeks. Then 10% of residents for 4 weeks. Ongoing audits will be determined by prior 12 weeks of results. The Point of Care Compliance Refindicates the date, the shift, the reside the category (restorative nursing), the schedule plan, and comment section. This is review daily by the restorative nurse. Issues identified will be addrest timely. An audit tool was completed to determine staff compliance with completing showers. This was initiate April 5, 2019. The audit will be addrest timely. 	ing will ion e d on eted a	

Facility ID: 923377

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	S FOR MEDICARE &					O. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			E SURVEY PLETED	
		345229	B WING		C		
	ROVIDER OR SUPPLIER	545225		STREET ADDRESS, CITY, STATE, ZIP CODE	04	/03/2019	
NAME OF P	ROVIDER OR SUPPLIER			1101 NORTH MORGAN STREET			
PEAK RE	SOURCES - SHELBY			SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
F 558	Continued From page	a 2	E 558				
F 558	and on 03/31/19. He days. *In April 2019, he was was walked on 04/02 out of 2 days. On 04/03/19 at 11:49 stated during intervie walk daily which was stated he could walk reasons the staff wan Interview with the res 04/03/19 at 11:51 AW restorative services to but they needed to be She stated that there aides scheduled to w to work the floor, one was on duty to perfor was unable to say wh walked but half the tir Interview with NA #3 11:58 AM revealed bo Both NAs stated they on the floor and that I provide services. The worked alone, they tr	was walked 15 out of 31 s not walked on 04/01/19 but /19. He was walked once AM, Resident #10 again w that he was not getting to what he wanted to do. He per himself but for safety ited him to have assistance. torative manager on I revealed that she aimed for o be provided 7 days a week e provided 6 times a week. was always 2 restorative ork so that if one was pulled restorative staff member m restorative duties. She by Resident #10 was not	F 558	 completed weekly by Director of N and/or Staff Development Coordir weekly on 25% of a random samp residents for 2 weeks. Then 10% residents for 6 weeks, then 5% of residents for 4 weeks. Ongoing a be determined by prior 12 weeks results. QAPI: " Administrator will report all an information and it will be reviewed analyzed at the monthly QAPI me 3 months. 	udits will of udits will of		
	Resident #10 had sta walk daily but they ca Interview with the Phy 04/03/19 at 3:50 PM very high functioning	ryone. NA #2 stated that ted to her that he wanted to an't do it due to staffing. ysical Therapist (PT) on revealed Resident #10 was and motivated. Resident bout not getting to walk. PT					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 04/24/2019 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE COMF	SURVEY PLETED
		345229	B. WING			_		C /03/2019
NAME OF PI	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		00/2010
	SOURCES - SHELBY			1	101 NORTH MORGAN ST	REET		
				S	HELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558	Continued From page	3	F	558				
		ined he was not walking and PT they had been pulled to have time to walk him.						
	Resident #10 was inte stated that he wanted receive 3 showers pe Wednesday and Satu	rday. He stated that red him three times a week						
	stated that when a rea facility, she interviewe times a week they had and/or wanted to rece placed their preference If a resident changed	PM Nurse Aide (NA) #4 sident was admitted to the ed them regarding how many d previously showered eive a shower. She then ce on the shower schedule. their mind, she would hedule to accommodate						
		lule, Resident #10 was to nes a week on Monday, ırday.						
		entation, he missed one 019 and three in March						
	short staffing. She stand not do a complete sho good bed bath. She s	vays getting done due to ated that when she could ower, she always provided a stated the documentation nowers were completed and						
	On 04/02/19 at 3:02 F	PM, NA #5 stated that she						

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM): 04/24/2019 // APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345229	B. WING					C 03/2019
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
PEAK RES	SOURCES - SHELBY				101 NORTH MORGAN STREET			
				3	SHELBY, NC 28150			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 558	Continued From page	• 4	Í F	558				
	has occasionally miss							
		e will make it up the next						
	day. She further state							
	should be reflective or were provided.	f exactly when showers						
	were provided.							
	-	with Resident #10 on						
		, he stated that he did get						
		sometimes but preferred h he wanted as scheduled						
	Monday, Wednesday							
		ector of Nursing (DON) and						
		3/19 at 4:08 PM revealed restorative care was not						
	-	at residents were missing						
	•	stated that although the						
		ame during first and second						
	shifts, there was more nurse aide on first shi	e work to be completed by ft.						
		dmitted to the facility on						
		ses including pneumonia,						
	heart failure, chronic i anxiety disorder.	espiratory failure and						
		um Data Set coded her with						
		aving no behaviors. She sistance with most activities						
	of daily living skills inc							
	During initial tour on 0	04/02/19 at 9:10 AM.						
	-	at the staff were busy and						
		e schedule to give her						
		they shower her when they						
		d just accepted the shower because they were short						
	staffed.	,						

Facility ID: 923377

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOF	RM APPROVED		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED		
		345229	B. WING			04/03/2019			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
PEAK RE	SOURCES - SHELBY				1101 NORTH MORGAN STREET SHELBY, NC 28150				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE		
F 558	On 04/03/19 at 2:58 F stated that when a re- facility, she interviewe times a week they ha and/or wanted to rece placed their preference If a resident changed update the shower so their preferences. Per the shower sched showered on Tuesday Review of the docum showers revealed that received 4 showers a 02/21/19, 03/27/19 at documentation reveal between. On 04/02/19 at 2:52 F showers were not alw short staffing. She st not do a complete sho good bed bath. She st would reflect when sh when they were not c On 04/02/19 at 3:02 F has occasionally miss scheduled but that sh day. She further state should be reflective o were provided. Upon follow up intervi 04/03/19 at 2:51 PM, nurse aides were very	PM Nurse Aide (NA) #4 sident was admitted to the ed them regarding how many d previously showered sive a shower. She then be on the shower schedule. their mind, she would thedule to accommodate dule, Resident #3 was to be ys and Thursdays. entation of Resident #3's t since admission, she had s documented on 02/13/19, nd 3/28/19. The led 13 bed baths in PM, NA #2 stated that vays getting done due to ated that when she could ower, she always provided a stated the documentation nowers were completed and ompleted. PM, NA #5 stated that she sed giving showers as e will make it up the next	F	558	3				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	(X3) DATE COMP	
		345229	B. WING				03/2019
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
PEAK RE	SOURCES - SHELBY				NORTH MORGAN STREET .BY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558 F 725 SS=D	"understands what it i she felt bad when sta other residents neede on admission she was preference and she to showers per week. W receiving a few shows stated that sounded a that if there was enou- showers per week bu in between partial and Interview with the Dirr Administrator on 04/0 they were not aware to being completed or the showers. Sufficient Nursing Sta CFR(s): 483.35(a)(1)(1) §483.35(a) Sufficient The facility must have the appropriate comp provide nursing and r resident safety and at practicable physical, for well-being of each res- resident assessments and considering the n diagnoses of the facil accordance with the f at §483.35(a)(1) The fac by sufficient numbers- types of personnel on	s like." She further stated ff would give her care when ed care also. She said that is asked about her shower old them at home she took 2 when asked about only ers since admission, she about right. She then stated gh staff she would take 2 t felt clean enough with the d bed baths. ector of Nursing (DON) and 3/19 at 4:08 PM revealed restorative care was not that residents were missing off (2) Staff. e sufficient nursing staff with etencies and skills sets to elated services to assure tain or maintain the highest mental, and psychosocial sident, as determined by a and individual plans of care		725			4/20/19

Facility ID: 923377

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		345229	B. WING			C 03/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PEAK RE	SOURCES - SHELBY			1101 NORTH MORGAN STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	CTION SHOULD BE COM O THE APPROPRIATE		
F 725	 (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides §483.35(a)(2) Except paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on resident in and documentation, the there was enough state walking assistance ar sampled residents de #10). The findings included Resident #10 was 12/31/18. His diagno unspecified atrial fibri weakness, and esser Resident #10's admiss dated 01/07/19 assess cognition, having no r and requiring extensiv Walking was coded a the look back period. for receiving physical a) A care plan was de restorative ambulation needed during walking knee amputation. Th 	ed under paragraph (e) of nurses; and sonnel, including but not when waived under section, the facility must nurse to serve as a charge duty. is not met as evidenced terviews, staff interviews he facility failed to ensure ff scheduled to provide nd showers as often 2 of 5 sired. (Residents #3 and admitted to the facility on ses included heart failure, llation, dermatitis, muscle tial hypertension. sion Minimum Data Set sed him with intact nood issues or behaviors, ve assistance with bathing. s not having occurred during Resident #10 was coded therapy. eveloped on 02/15/19 for n for him to be assisted as g related to a right above e goal was to ambulate 200 assistance using a rolling	F 72	 F725 Sufficient Nursing Staffing Resident #10 had no adverse effects regard to not being ambulated daily. Resident #10 has been receiving restorative as recommended. Resid #3 had no adverse effects with regar not being showered per schedule. Resident #3 has had showers as not the Point of Care records, the reside was discharged on 4/9/19. Measures in place: Nurse staffing patterns reviewed alou with the residents needs during labo meeting held daily Monday through Friday. Attendees are including, the Administrator, Director of Nursing, S Development Coordinator, and Schee The facility has continued recruiting posting ads on our website, Indeed, newspaper, zip recruiter, job videos, facebook, and twitter. Sign on bonus and pick-up bonuses offered. Orient for new employees are scheduled as needed and may be multiple times a 	ent d to eed on nt ng r taff duler. my local ses tation		

Facility ID: 923377

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CENTER STATEMENT (AND PLAN OF NAME OF PL PEAK RES (X4) ID	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER SOURCES - SHELBY	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345229	A. BUILDIN B. WING _ ID	NG	CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE IO1 NORTH MORGAN STREET HELBY, NC 28150 PROVIDER'S PLAN OF CORF	RECTION	FORM OMB NO (X3) DATE COMPI (04/0	LETED C D3/2019 (X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI> TAG	((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)			COMPLETION DATE
F 725	the number of times p with assistance. During initial tour, on P Resident #10 was inter observed to have an a and a prosthesis local interview, Resident #1 the restorative service included assisting him walking. On 04/02/19 at 2:55 F caring for Resident #1 stated that she norma aide but was sometim work. She stated that restorative aide over the pulled to the floor to c further stated that Res over the weekend. Si #10 was able to apply Review of the restoral no specific number of scheduled to walk. Do provided revealed that restorative ambulation through 04/02/19, Res restorative services a *In February 2019, he 02/15/19, 02/17/19, 0 02/22/19 and 02/24/11 14 days. *In March 2019, he w 03/03/19, 03/04/19, 0	plan was not specific as to ber week he should walk 04/02/19 at 9:20 AM, erviewed. Resident #10 was amputation of his left leg ted at bedside. During the 10 stated he did not receive as he wanted daily which in with his prosthetic leg and PM the nurse aide (NA #1) 10 was interviewed. NA #1 11 worked as a restorative les pulled to the floor to it she was scheduled to be a he past weekend but was over as a nurse aide. She sident #10 was not walked he also stated that Resident in the prosthesis himself. The prosthesis himself. The prosthesis himself.	F 7	725	based on open positions. Monitoring Staffing patterns and open posi- reviewed daily at Labor meeting. Administrator, DON, SDC, and Specific open nursing positions added as needed and recruitme- initiated. The daily assignment audited and reviewed at the Lai- meeting to address any call out issues are resolved at that time assignment is initialed by the D Nursing or other administrative validate the daily assignment sl been reviewed. This was initial 10, 2019. On the weekends the supervisor reviews the daily sch replaces staff as necessary. The scheduling issues to the Director Nursing. This process has beer and will continue to assure that sufficient nursing staff to care for resident needs. QAPI Administrator will report all audi- information and it will be review analyzed at the monthly QAPI re- 3 months.	g held by Schedu a area ent is t sheet is bor ts. Staff e. The d Director of nurse to heet has ted on A he eport any or of n ongoin t there is or the	y ler. S aily of s pril and y	

Facility ID: 923377

If continuation sheet Page 9 of 15

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345229	B. WING			04/03/2019		
NAME OF P	ROVIDER OR SUPPLIER	L		Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
PEAK RE	SOURCES - SHELBY				1101 NORTH MORGAN STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 725	days. *In April 2019, he was was walked on 04/02, out of 2 days. On 04/03/19 at 11:49 stated during interview walk daily which was stated he could walk reasons the staff wan Interview with the res 04/03/19 at 11:51 AM restorative services to but they needed to be She stated that there aides scheduled to we to work the floor, one was on duty to perfor was unable to say wh walked but half the tir Interview with NA #3 11:58 AM revealed bo also. Both stated the the floor and that left provide services. The worked alone, they tri services completed b could not service eve Resident #10 has sta walk daily but they ca Interview with the phy 04/03/19 at 3:50 PM i	AM, Resident #10 again w that he was not getting to what he wanted to do. He per himself but for safety ted him to have assistance. torative manager on revealed that she aimed for be provided 7 days a week e provided 6 times a week. was always 2 restorative ork so that if one was pulled restorative staff member m restorative duties. She by Resident #10 was not ne. and NA #4 on 04/03/19 at oth were restorative aides y often get pulled to work on one restorative aide to ey stated that when they ied to get all restorative ut that most of the time they ryone. NA #2 stated that ted to her that he wants to	F	725				

Facility ID: 923377

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		345229	B. WING			04/03/2019		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
PEAK RE	SOURCES - SHELBY				1101 NORTH MORGAN STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 725	restorative reported to the floor and did not h b) During initial tour, of Resident #10 was inte stated that he wanted receive 3 showers pe Wednesday and Satu generally they shower with occasional misse On 04/03/19 at 2:58 F stated that when a res facility, she interviewe times a week they had and/or wanted to rece placed their preference If a resident changed update the shower so their preferences. Per the shower scheor receive a shower 3 tir Wednesday and Satu Review of the docume shower in February 22 2019. On 04/02/19 at 2:52 F showers were not alw short staffing. She st not do a complete sho good bed bath. She s would reflect when sh when they were not c	 b PT they had been pulled to have time to walk him. b 0 04/03/19 at 9:20 AM, erviewed. Resident #10 c and was scheduled to r week on Monday, arday. He stated that red him three times a week ed showers. PM Nurse Aide (NA) #4 sident was admitted to the ed them regarding how many d previously showered eive a shower. She then be on the shower schedule. Their mind, she would the edule to accommodate d ule, Resident #10 was to mes a week on Monday, arday. entation, he missed one 019 and three in March PM, NA #2 stated that vays getting done due to ated that when she could ower, she always provided a stated the documentation howers were completed and 	F	725	5			

If continuation sheet Page 11 of 15

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 04/24/2019 APPROVED . 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED		
		345229	B. WING			04/0	;)3/2019	
NAME OF PR	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	FE, ZIP CODE			
	OURCES - SHELBY		1	101 NORTH MORGAN STRE	ET			
			5	SHELBY, NC 28150				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	YLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
F 725	Continued From page scheduled but that sh day. She further state should be reflective of were provided. On follow up interview 04/03/19 at 11:49 AM "washed up" by staff s getting a shower whic Monday, Wednesday On 04/03/19 at 3:29 F was interviewed. She scheduled one nurse of the 4 halls during fi staff call out she tried her "as needed" staff. restorative staff were perform regular nurse restorative staff memb services. She stated per week. She furthe do complain about be has told her care was Interview with the Dire Administrator on 04/0 they were not aware r	 11 e will make it up the next ed the documentation is exactly when showers with Resident #10 on the stated that he did get sometimes but preferred the wanted as scheduled and Friday. 20 When the staffing coordinator estated that she generally and 2 nurse aides for each for the vacancy with the stated lately being pulled to the floor to aide duties which left 1 over to complete restorative this occurred about 3 times in stated that although staffing short staffed, no one 	F 725					
	scheduling was the sa	stated that although the ame during first and second work to be completed by ft.						
		dmitted to the facility on es including pneumonia, espiratory failure and						

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	-	ID 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 COMF	(X3) DATE SURVEY COMPLETED	
		345229	B. WING			04/03/2019		
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PEAK RE	SOURCES - SHELBY				1101 NORTH MORGAN STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	ECTIVE ACTION SHOULD BE COMPLETIC DATE		
F 725	Resident #3's admiss coded her with intact behaviors. She requir with most activities of bathing. During initial tour on O Resident #3 stated th can't work into the scl She stated they show and she has just acce as it is as they are sh On 04/03/19 at 2:58 F stated that when a resi facility, she interviewe times a week they ha and/or wanted to rece placed their preference. If a resident changed update the shower sch their preferences. Per the shower sched showered on Tuesday Review of the docume showers revealed that received 4 showers a 02/21/19, 03/27/19 ar documentation reveal between. On 04/02/19 at 2:52 F showers were not alw short staffing. She st not do a complete sho	ion Minimum Data Set cognition and having no red extensive assistance daily living skills including 04/02/19 at 9:10 AM, at the staff are busy and hedule to give her showers. ver her when they have time epted the shower schedule ort staffed. PM Nurse Aide (NA) #4 sident was admitted to the ed them regarding how many d previously showered eive a shower. She then be on the shower schedule. their mind, she would thedule to accommodate dule, Resident #3 was to be ys and Thursdays. entation of Resident #3's tt since admission, she has s documented on 02/13/19, nd 3/29/19. The	F	725				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/24/2019 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345229	B. WING		_	(04/) 03/2019
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
PEAK RES	SOURCES - SHELBY			101 NORTH MORGAN ST SHELBY, NC 28150	REET		
(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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	has occasionally miss scheduled but that sh day. She further state should be reflective o were provided. Upon follow up intervi 04/03/19 at 2:51 PM, nurse aides were very was only 1 nurse aide "understands what it i she felt bad when sta other residents neede on admission she was preference and she to showers per week. W receiving a few showe stated that sounded a that if there was enou showers per week bu in between partial and On 04/03/19 at 3:29 F was interviewed. She scheduled one nurse of the 4 halls during fi staff call out she tried her "as needed" staff. restorative staff were perform regular nurse	ompleted. PM, NA #5 stated that she sed giving showers as e will make it up the next ed the documentation f exactly when showers with Resident #3 on Resident #3 stated that the y busy and sometimes there e on the hall. She stated she s like." She further stated ff would give her care when ed care also. She said that s asked about her shower old them at home she took 2 When asked about only ers since admission, she about right. She then stated gh staff she would take 2 t felt clean enough with the d bed baths. PM, the staffing coordinator e stated that she generally and 2 nurse aides for each rst and second shifts. If to cover the vacancy with She stated lately being pulled to the floor to a aide duties which left 1	F 725		DEFICIENCY)		
	services. She stated per week. She furthe	ber to complete restorative this occurred about 3 times r stated that although staff ing short staffed, no one not being done.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/24/2019 RM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	(X3) DATE SURVEY COMPLETED	
345229			B. WING				C 04/03/2019	
NAME OF PROVIDER OR SUPPLIER				5	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
PEAK RESOURCES - SHELBY					1101 NORTH MORGAN STREET SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 725	Interview with the Dire Administrator on 04/0 they were not aware in being completed or the showers. The DON scheduling was the sa	ector of Nursing (DON) and 3/19 at 4:08 PM revealed restorative care was not nat residents were missing stated that although the ame during first and second e work to be completed by	F	725				

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