PRINTED: 03/30/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION S		(X3) DATE SURVEY COMPLETED	
		345229	B. WING		C 03/23/20)21	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	1 00/20/20	· <u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COM	(X5) IPLETION DATE	
F 000	INITIAL COMMENTS	S	F 00	00			
	Additional information through 03/12/2021. revision to the Imme on 3/23/21. Therefor to 03/23/2021. There investigated it was some facility was notificated.	on and exited on 02/24/21. In was obtained offsite The Administrator provided a diate Jeopardy Removal Planire, the exit date was changed e was one allegation					
	Immediate Jeopardy CFR 483.12 at tag F	was identified at: 600 at a scope and severity					
	(J) Immediate Jeopardy was removed on 03/	began on 11/07/2020 and					
		tuted Substandard Quality of					
	An extended survey 03/11/2021.						
F 580 SS=D	Notify of Changes (In CFR(s): 483.10(g)(1	njury/Decline/Room, etc.) 4)(i)-(iv)(15)	F 58	30	4/8/2	21	
	consult with the resid consistent with his o representative(s) wh (A) An accident invo	nediately inform the resident; dent's physician; and notify, r her authority, the resident					
ABORATORY	 DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUI	 RF	TITLE	(X6) DA	TE.	

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.

Electronically Signed

03/19/2021

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345229	B. WING		C 03/23/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	1 00/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 580	mental, or psychoso deterioration in healt status in either life-th clinical complication. (C) A need to alter traneed to discontinual treatment due to advocmmence a new for (D) A decision to transident from the fact §483.15(c)(1)(ii). (ii) When making nor (14)(i) of this section all pertinent informatics available and proving physician. (iii) The facility must resident and the	inge in the resident's physical, cial status (that is, a th, mental, or psychosocial preatening conditions or s); reatment significantly (that is, a e an existing form of prese consequences, or to rm of treatment); or eafer or discharge the cility as specified in stification under paragraph (g) and the facility must ensure that the facility must ensure that the specified in \$483.15(c)(2) and ded upon request to the sident representative, if any, and or roommate assignment as specified in paragraph on. The record and periodically (mailing and email) and	F 580		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345229	B. WING		C 03/23/2021
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET SHELBY, NC 28150	00/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 580	under §483.15(c)(9) This REQUIREMEN by: Based on record refacility failed to notify resident began to excondition for 2 of 3 r notification of chang #2). Findings included: 1. Resident #1 was 07/07/20 with diagnore cerebrovascular acconstima.	een its different locations T is not met as evidenced view and staff interviews the y the Physician when a xperience a change of esidents reviewed for e (Resident #1 and Resident re-admitted into the facility on psis which included ident (CVA), anxiety and	F 580	F580 This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submissi of this plan of correction is not an admission that a deficiency exists or tone was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	e on hat
	Minimum Data Set (revealed she was al required extensive a member for most ac Resident #1 was con therapy during the a Review of Resident and revised on 11/0 respiratory care due for shortness of brea asthma. An interven Physician if shortnes Review of a Physicia dated 07/30/20 reve experiencing any of	#1's care plan dated 06/16/17 9/20 revealed a focus area for to Resident #1 being at risk ath related to a history of tion included notifying the as of breath occurred. an order for Resident #1 aled if the resident was the following symptoms of breathing or difficulty		Residents Affected: Resident #1 was discharged to the hospital on November 7, 2020 at 9:30 and did not return to the facility. Resident #2 was discharged to the hospital on November 7, 2020 and returned to the facility on November 1 2020 with a diagnosis of pneumonia related COVID 19 infection. Residents with potential to be affected All residents identified with a change if condition have the potential to be affected by the alleged deficient practice. All residents medical records were reviewed for an identified change in condition during the past 14 days to	3, 1: n

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	COME		DATE SURVEY COMPLETED
		345229	B. WING _			C 03/23/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1101 NORTH MORGAN STREET SHELBY, NC 28150	E	03/23/2021
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 580	Review of a nursing at 3:54 PM written by #1's Responsible Pa stated Resident #1 s Nurse #1 checked of an oxygen saturation 92-100%). The note oxygen at 4 liters pe #1's oxygen level be 92%. Review of a nursing at 4:41 PM written by gone into Resident # cannula tubing on th of in her nose. Residevel was at 70%. Nu cannula into Resider	progress note dated 11/07/20 / Nurse #1 revealed Resident rty (RP) had called and ounded short of breath. In Resident #1 to find she had a level of 72% (normal range revealed Nurse #1 initiated or minute (lpm) and Resident gan to rise to 89%, 90% to progress note dated 11/07/20 / Nurse #1 revealed she had in the resident's forehead instead the resident's forehead instead the masal of the resident with the	F 5	ensure that the appropriate not the physician or physician extresident representative were residents in nursing progress resigns, and physician orders to changes in the residents med mental condition that would rephysician or physician extend resident representative notific audit was completed by the A and reviewed by the Regiona Manager on 3/18/2021. All reappropriate documentation of of physician or physician exteresident representative. No of was adversely affected by the deficient practice.	ender and conducted. of the notes, vital passess for ical and/or equire er and eation. This dministrator I Clinical sidents had notification and ther resident	
	conducted with Resident (RP). During the interpretation of the spoken to Resident (RP) and to the spoken to Resident (RP) and the stated to him she feltoward to the stated he hung up the and called Nurse #1 room and checked he which was low. He similated supplementation RP stated he called later to ask how she short of breath. Whe wearing oxygen, she called the nurses stated to tell her what Resident (RP) and the short of the stated her stated the stated the stated the stated (RP).	AM an interview was dent #1's Responsible Party rview he stated he had #1 on the afternoon of e sounded out of breath and t short of breath. The RP e phone with Resident #1 Nurse #1 then went into the er oxygen saturation level tated he was told Nurse #1 al oxygen at that time. The Resident #1 back two hours was doing, and she was still in he asked her if she was e stated no. The RP then tion and spoke with Nurse #1 dent #1 had said. He stated t into the room the resident		System changes: 1. The Regional Clinical Mareviewed the policy for Change Resident S Condition on Mare This policy includes the follow. The nurse will notify the resident attending physician or on-call when there has been: "An accident or incident in resident. "A discovery of injuries of source. "A reaction to medication. "A significant change in the	ge in a rch 18, 2021. ving: ent⊡s physician rvolving the an unknown	

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 _			1	C / 23/2021
NAME OF PR	ROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2021
					101 NORTH MORGAN STREET		
PEAK RES	SOURCES - SHELBY				HELBY, NC 28150		
				3	HELBI, NC 20190		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page	e 4	F 5	580			
F 580	was in fact not wearing the oxygen back into oxygen level increased called back, he spoke how Resident #1 was she hadn't been into check on her. The RI wanted Resident #1 evaluation. The intercalled him back and at the Director of Nursing who both recomment to the hospital because respiratory distress a wanted her sent to the Emergency Medical at which he did. On 02/24/21 at 11:13 conducted with Nurse on 11/07/20 she was NA #1 stated Reside confused during the Nurse #1. NA #1 stat Nurse #1 the resident had not eaten her bronoticed when she pict stated she did not kn Resident #1's room to find her in the	ng her oxygen, she placed Resident #1's nose and her ed. The RP stated when he e with Nurse #2 and asked s doing. She stated to him the room yet, but she would P stated he told Nurse #2 he sent to the hospital for an view revealed Nurse #2 stated she had spoken with ng and Nurse Practitioner ded the resident not be sent se she appeared to be in no t that time. He was told if he he hospital, he could call Services (EMS) himself in AM an interview was e Aide (NA) #1. She stated taking care of Resident #1. Int #1 was acting strange and morning, so she notified ed around 11:00 AM she told t was breathing heavy and eakfast meal which was eked up the trays. NA #1 ow if Nurse #1 went into to check on her. She stated went back into Resident #1's the same condition continuing breathing so she notified	F	580	physical/emotional/mental condition. A need to alter the resident □s mentreatment significantly. Refusal of treatment or medication (i.e. two (2) or more consecutive times A need to transfer the resident to a hospital/treatment center. A discharge without proper medical authority. Instructions to notify the physician changes in the resident □s condition. Unless otherwise instructed by the resident □s next-of-kin or representative when: The resident is involved in any accident or incident that results in an injury including injuries of an unknown source and has the potential of requiring physician intervention. There is a significant change in the resident □s physical, mental, or psychosocial status; (i.e. a deterioration health, mental, or psychosocial status either life-threatening conditions or clin complications). A need to alter treatment significant (i.e. a need to discontinue an existing form of treatment due to adverse consequences, or to start a new form of the status of the start and the st	ns). a al of e ng e n in in ical	
	Nurse #1 again. The #1's responsible part well and notified her breath. When Nurse obtain an oxygen sat was in the 70% range	interview revealed Resident y had called Nurse #1 as of Resident #1's shortness of #1 entered the room to uration level NA #1 stated it e (normal 92-100%). She ran down the hall to obtain			treatment. " There is a need to change the resident s room assignment. " A decision has been made to discharge the resident from the facility; and/or " It is necessary to transfer the resident from the resident from the resident from the facility;		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE : AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		SURVEY PLETED					
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		345229	B. WING _			03/	23/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1	101 NORTH MORGAN STREET		
PEAK RES	SOURCES - SHELBY			S	SHELBY, NC 28150		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLÉTION DATE
F 580	Continued From page	e 5	F 5	580			
		tor and applied oxygen to sal cannula. The interview			to a hospital/treatment center.		
	revealed after Nurse	#1 applied oxygen to			Except in medical emergencies,		
		seemed confused removing			notifications will be made within		
	the oxygen tubing cau	using her oxygen level to			twenty-four (24) hours of a change		
	drop.				occurring in the resident□s		
					medical/mental condition or status.		
		AM an interview was					
conducted with Nurse #1. She stated on 11/07/20 she was responsible for Resident #1 during the					The nurse will record in the resident □s		
				medical record information relative to			
		shift. Nurse #1 stated she			changes in the resident ☐s medical/me	ntal	
	had received a phone call from Resident #1's responsible party around 3:30 PM who said she				condition or status.		
	was experiencing sho				No changes were made to the policy.		
		stated she did not recall NA			No changes were made to the policy.		
		saying anything was wrong			2. One on one education was provide	ed	
	ū	vever it had been a while and			to Nurse # 1 and Nurse #3 by the Direct		
		en. Nurse #1 stated she			of Nursing on the policy Change in a		
		t's room with the RP still on			Resident Condition. This was complete	ed	
	the phone and checke	ed her oxygen level to find a			on February 26, 2021		
	low reading. The inter	rview revealed she ran from					
	the resident's room to	get an oxygen concentrator			All licensed nursing staff will be		
		via nasal cannula at 4 liters			educated by the Staff Development		
	and Resident #1's oxy				Coordinator, Director of Nursing and/or		
	•	stated she received a second			Nurse Supervisor regarding the Chang		
		's RP around 4:30 PM			Resident Condition policy. This educat	ion	
	stating the resident w				was initiated on 3/18/2021 by the		
		nd to go and check on her.			Administrator and Regional Clinical		
		e room Resident #1 did not			Manager and will continue to be provid		
		and her oxygen saturation			to all licensed nursing staff. This will b	е	
		She stated she placed the nto Resident #1's nose and			completed by 4/1/2021. Any licensed	ar.	
		eased to 90%. The interview			nursing staff out on leave of absence of on PRN status will be educated prior to		
		the information along to the			returning to their assignment by the Sta		
	•	ring shift change however			Development Coordinator, Director of	411	
		cian of Resident #1's change			Nursing and/or Nurse Supervisor. New	lv	
		supplemental oxygen. She			hired licensed nursing staff will be	- 7	
		el like she needed to since			educated during orientation by the Stat	ff	
		level had increased on 4			Development Coordinator.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
		345229	B. WING _		0	C 3/23/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	<u> </u>	9,29,292.
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F 580	Continued From pag liters.		F 5	Monitoring:		
	conducted with Nurs responsible for Resid the 7:00 PM to 7:00 as he had received repthe interview she staduring shift change the experienced a change supplemental oxyger had not worn oxyger interview revealed R her around 8:30 PM medication pass states sent to the hospital fointerview revealed she started her medication Resident #1's room yinto Resident #1's roorespiratory distress.	ne requiring the need for n. She stated Resident #1 n prior to that day. The resident #1's RP had called during the middle of her ring he wanted Resident #1 or an evaluation. The ne had received report and on pass not making it to ret. Nurse #2 stated she went om to find her in no She stated she obtained vital		An audit tool was developed to physician or physician extende resident representative have be of any change in the resident mand/or mental condition. The audit tool consists of the form. "The resident physician has notified of the residents change condition. "The Resident representation notified of the resident change condition. "Appropriate clinical docume evident.	r and the een notified nedical bllowing: s been e in ve has been of nentation is	
	signs and they were did not chart them are what they were. She Nursing (DON) who was Practitioner or ordered a nebulizer to needed and a chest NP told her if the fam Medical Services the resident was in no resee the need to send RP contacted Emerg (EMS) and Resident hospital at 9:30 PM.	within normal limits however and couldn't not remember notified the Director of was in the building and the normal. The Nurse Practitioner reatment every 4 hours as ex-ray. Nurse #2 stated the nily wanted to call Emergency by could however if the espiratory distress, she didn't at them out. She stated the ency Medical Services #1 was transported to the desident #1 had a diagnosis		During the morning clinical tean Monday through Friday, the Din Nursing and/or Nursing Supervive review the progress notes, vital physician orders of all residents for any change in condition required medical intervention or an alter current plan of care and proper notification of physician and reserversentative from the previous hours. During the Monday clinic meeting, the Director of Nursing Nurse Supervisor will review the documentation for Friday through Audits will be completed on 100 residents with an identified chastatus daily, Monday through Fweeks, then 50% of the residents	rector of risor will I signs, and sto review uiring ration in the sident us 24 cal team g and/or e same gh Sunday. 0% of the inge in riday x 2	

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		OMPLETED
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	IDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1101 NORTH MORGAN STREET SHELBY, NC 28150		00/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
en Re ac Ro inf ho ble Or co Dr at the Pr far inj to the re sta bu the Or co (N sta pr or or or sta pr or or sta pr or or sta pr or sta pr or sta pr or sta pr or sta pr or sta pr or sta pr or sta pr or sta pr or sta pr or sta pr or sta pr or sta pr or sta p or sta p c or sta p or sta p or sta p or sta pr or sta p or sta p c or sta p c or sta p or sta p or sta p c or sta p c sta p c or sta p c or s or sta p or sta p c or sta p c or s or sta p c or s or sta p c or s or s ta p c or sta p c or s or s ta p c or s ta p c or s ta p c or s or s or s or s or s or s or s or	esident #1 was too diditional history who com and her responson and responson at 127/5 vel of 92% on 4 lite on 02/24/21 at 12:39 onducted with the During the interview structed and if there nurse was responsysician immediate cility on 11/07/20 wight shift. The DON her stating the RP e hospital but that his ident was in no related she did not go at told Nurse #2 to jut told Nurse #2 to jut resident was in no 100/25/21 at 8:30 and and would need she aff to notify her if the reviously did not reconstructed with the fact would be considered with the fact would be considered with the Nated when he reviewated with the Nated with the Nated with the Nated when he reviewated with the Nated when he reviewated with the Nated with the Nated when he reviewated with the Nated with	ia. The report revealed lethargic to give any en seen in the Emergency nsible party had given the t #1's vital signs at the ature 102, heart rate 95, 2 and oxygen saturation	F 5	x 4 weeks, then 25% of the every two weeks x 6 weeks. the audits will determine the further monitoring. Audits will be completed on residents with an identified of status daily, Monday through weeks, then 50% of the resi x 4 weeks, then 25% of the every two weeks x 6 weeks. the audits will determine the further monitoring. QAPI: The results of the audits will the monthly QAPI meeting be review and recommendation. Completion date: April 8, 20	The results of e need for 100% of the change in h Friday x 2 dents weekly residents. The results of e need for I be brought to by the DON forns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			1 ,	С	
		345229	B. WING				23/2021	
NAME OF PI	ROVIDER OR SUPPLIER		ı	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2021	
					1101 NORTH MORGAN STREET			
PEAK RES	SOURCES - SHELBY				SHELBY, NC 28150			
	OLIMANA DV	OTATEMENT OF REFIGIENCIES					0.5	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC 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 580	Continued From pa	ge 8	F	580				
	-	te the nurse's assessment						
		s experiencing no respiratory						
		ated hypoxia (the absence of						
		he tissue to sustain bodily						
		ual respiratory distress. The						
		ne did not send residents out						
	for respiratory distre	ess unless they were in active						
	accessory muscle of	listress which it did not seem						
	like Resident #1 wa							
	oxygen saturation le							
	supplemental oxyge							
	noted to be confuse							
	did not have the me							
		en to be useful which is why						
	_	t. The MD stated the NP had						
		treatment and chest x-ray						
		fied her. He stated looking at						
	_	notes from 11/07/20 since he g the situation was a clinical						
		sponsible party was insistent						
		ne hospital then they would be						
		t to call emergency medical						
	_	riew revealed it was the facility						
		sidents on prophylactic						
	I -	ner) when diagnosed with						
	l	ed she was diagnosed with						
	COVID-19 pneumo	nia at the hospital and had a						
	pulmonary embolisi	m which could not have been						
	prevented if she had	d been sent to the hospital any						
		s. The interview revealed						
	,	poxic was placed on						
		en with her oxygen saturation						
		nrew a clot and ended up with						
		ism. He stated there was no						
	, ,	d have known that was						
	occurring.							
	2 Posident #2 was	ro admitted into the facility or						
		re-admitted into the facility on osis which included acute						

	DF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345229	B. WING				23/2021	
	ROVIDER OR SUPPLIER		1	1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET SHELBY, NC 28150	1 03/	23/2021	
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F 580	Minimum Data Set (Norevealed she was ale required extensive as member for most acti Resident #1 was code therapy during the as Review of Resident #1 revealed a focus area intervention included Review of Resident #1 Physician orders revealed to Physician orders revealed to Physician orders revealed of Physician orders revealed of Physician orders revealed to Physician dated 07/30/20 revealed the following shortness of the physician orders revealed the following shortness of the physician orders revealed the following shortness of the physician o	2's most recent quarterly (IDS) dated 11/18/20 rt and oriented. Resident #1 sistance of one staff vities of daily living (ADL). ed as receiving oxygen sessment period. 2's care plan dated 02/25/20 of for respiratory care. An oxygen therapy as ordered. 2's November 2020 ealed an order initiated on "Maintain oxygen saturation 10% every shift." In order for Resident #2 led if the resident was the following symptoms of breathing or difficulty to Physician. 2's vital signs on 11/07/20 gt: AM: Oxygen saturation level supplemental oxygen. I PM: Oxygen saturation significant of supplemental oxygen.	F	580				

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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	.	00/20/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 580	11/06/20 from 11:00 stated she remember experiencing a low on or remember if she oncoming first shift in notify the Physician under the facilities in Urgent and could be during that time she was still learning as On 02/25/21 at 9:05 conducted with Nursishe was responsible 7:00 AM to 7:00 PM she did not receive at Resident #2's low on stated she was not at went into Resident # obtain vital signs and saturation level of 62 oxygen via nasal can #2 was alert but leth COVID-19. Nurse # appearance you cous atturation level was she increased Reside and notified the Physical the resident to evaluation. Review of the Event PM revealed Resided due to an onset of rehad increased her on Physician. Resident were Oxygen satural	dent #2 during third shift on PM to 7:00 AM. Nurse #3 ared Resident #2 axygen saturation level but did had notified the Physician or nurse. She stated if she did it would have been listed offication system called pulled up. Nurse #3 stated was new to the facility and a new nurse. AM an interview was are #1. She stated on 11/07/20 afor Resident #2 during the shift. The interview revealed anything in report regarding axygen saturation levels. She aware of anything until she is 2's room at 11:30 AM to did received an oxygen 2% on 2 liters of supplemental annula. She stated Resident argic due to a diagnosis of a stated from Resident #2's oxygen to 4 liters sician who gave orders to	F 5	80			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345229	B. WING			С	
	ROVIDER OR SUPPLIER SOURCES - SHELBY	343229	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150		03/23/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED (EACH CORRECT CO	ULD BE	(X5) COMPLETION DATE	
F 580	pressure 127/63 and minute. Review of Resident # 11/07/20 revealed she facility to the hospital saturation levels rang was placed on 15 lite mask once at the hos COVID-19 positive. It is status was document bilateral with bilateral hospital diagnosis in COVID-19 virus, bilat respiratory failure with Review of the facilitie revealed no record of Physician of Residen levels. On 02/24/21 at 12:39 conducted with the D She stated Resident on the same day as Fresidents had a staturevealed she was una experiencing an oxyg 70% range throughout 11/07/20 and stated to been reported to the communication board she could not find whithe Physician regardilevel. The interview residents was the could resident to the could not find whithe Physician regardilevel. The interview residents was the could not find whithe Physician regardilevel. The interview residents was the could not find whithe Physician regardilevel.	respirations 18 beats per 22's hospital records dated e was admitted from the with hypoxia and oxygen ging in the 70%. Resident #2 rs via a non-rebreather epital and was confirmed desident #2's respiratory ed as diminished air entry rhonchi. Resident #2's clude pneumonia due to deral pneumonia and de hypoxia. Is notification system In Nurse #3 notifying the to #2's low oxygen saturation PM an interview was director of Nursing (DON). #2 was sent to the hospital Resident #1 and both desident #1 and both desident #1 and both desident #2 den saturation level in the dut the early morning on desident was the dut the dut the was the dut the dut the was the dut the was the dut the dut the was the dut the dut the was the dut the was the dut the d	F 58				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		((X3) DATE SURVEY COMPLETED				
		345229	B. WING				23/2021
	ROVIDER OR SUPPLIER SOURCES - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 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		HOULD BE		(X5) COMPLETION DATE
F 580 F 600 SS=J	(NP). She stated she staff to notify her if the low oxygen saturation period of almost 4 ho would be considered would need to be add On 02/26/20 at 8:40 A conducted with the M stated he was not fan however on 11/07/20 been reported to the stated they should be change in condition woxygen level in the 70 have went on for an einterview revealed his responsible nurse to sign, keep the resider on-call Physician so and the situation be refere from Abuse and CFR(s): 483.12(a)(1) §483.12 Freedom fro Exploitation The resident has the neglect, misappropria and exploitation as deincludes but is not lim corporal punishment, any physical or chem treat the resident's me §483.12(a) The facility	cility Nurse Practitioner would expect the nursing ey had a resident who had a n level of 75 to 76% for a urs. The NP stated that a change in condition and dressed immediately. AM an interview was edical Director (MD). He niliar with Resident #2 her vital signs should have on-call Physician. The MD enotified immediately of a where a resident has an own range, and it should not extended period of time. The expectation was for the notice the abnormal vital ent comfortable and call the orders could be obtained, esolved. Neglect M Abuse, Neglect, and right to be free from abuse, attion of resident property, efined in this subpart. This inted to freedom from involuntary seclusion and ical restraint not required to edical symptoms.		600			4/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
			A. BOILDI	_		Ι ,	3
		345229	B. WING			1	23/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
DEAK DE	SOURCES - SHELBY			1	101 NORTH MORGAN STREET		
PEAN NE	SOURCES - SHELDT			S	HELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From pag physical abuse, corp involuntary seclusion	oral punishment, or ;	F	600			
	by: Based on record revinterviews, the facility seriousness of low or assess the residents medical interventions medical attention or residents who experisaturation levels. As maintained a low oxy from 66% to 76% (no 92%) for a 9-hour pehospitalization. Residents who experisaturation levels. As maintained a low oxy from 66% to 76% (no 92%) for a 9-hour pehospitalization. Resident in the tissue level) are severe acute respirar pneumonia and was that pushes air into the sudden onset of low and oxygen therapy assessments. A fame Emergency Medical #1 transferred to the was diagnosed with pulmonary embolism	exygen saturation levels, a provide nursing and a provide nursing and a provide nursing and a provide nursing and a result, Resident #2 and a result, Resident #2 and a resulting in a provide ranging a resulting in a provide range greater than a riod resulting in a provide range of adequate oxygen supply and was diagnosed with a rory failure and COVID-19 placed on a BiPAP (machine and le lungs). Resident #1 had a provide range of 72% and was initiated without ongoing a resident whospital where the resident covide resident and with hypoxia. This was for 2 transport a resident respiratory			F600 This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submissio of this plan of correction is not an admission that a deficiency exists or the one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. Affected residents: Resident #1 was admitted to the hospit on 11/07/2020 with Covid-19 pneumon and pulmonary embolism. Resident #1 not return to the facility. Resident #2 was admitted to the hospit on 11/07/2020 with hypoxia. Resident treated at the hospital and subsequent returned to the facility on 11/13/2020. Residents with potential to be affected.	n at al ia did tal was ly	
	Resident #1 and #2 I condition with the hig outcomes, and the famedical services. The removed on 03/06/2 and implemented an	began on 11/07/20 when both had acute changes of the likelihood for serious acility failed to respond with the immediate jeopardy was I when the facility provided acceptable credible			An audit was completed by the Administrator on 03/05/2021. The Administrator reviewed all residents whare currently on oxygen therapy or hav received oxygen therapy in the last 72 hours to determine if any other residently and enjoyees of oxygen desaturation as	e t	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345229	B. WING			C 3/23/2021	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODI		0/20/2021	
DE 414 DE 6				1101 NORTH MORGAN STREET			
PEAK RES	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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 600	Continued From page	e 14	F 60	00			
	facility remains out of	f compliance at a lower		if so, was the MD/NP/PA notifi	ed and		
		vel of "D" (No actual harm		appropriate interventions appl			
		e than minimal harm that is		addition, all physician orders f			
	not immediate jeopar	dy) to ensure monitoring		administration were reviewed			
	systems put into place	e are effective.		that all orders had parameters	for		
				notification of MD/NP/PA. All p	ohysician		
	The findings included	l:		orders state to notify the MD/N			
				oxygen saturations <90% and			
		dmitted to the facility on		oxygen saturations >90%. The			
		nosis which included chronic		additional potentially affected			
	obstructive pulmonar	y disease (COPD).		however, no additional resider			
	Povious of Posidont +	t2's most recent annual		identified as having been affect alleged deficient practice. All	•		
	Review of Resident #2's most recent annual Minimum Data Set (MDS) dated 11/02/20			had orders for parameters of r			
		gnitively intact. Resident #2		No resident had oxygen satura			
	required extensive as	= =		<90%.			
		ivities of daily living (ADL).					
		ed as not receiving oxygen					
	therapy during the as			System Changes:			
	Review of Resident #			Nurse # 1 and Nurse #3 was			
	_	ealed an order initiated on		the Director of Nursing on 02/			
		"Maintain oxygen saturation		regarding the importance of or			
	levels greater than 90	J% every shiit.		saturation readings; to notify N			
	Review of Resident +	2's active care plan initiated		any oxygen saturation level < i increase the oxygen administr			
		a focus area for respiratory		maintain the oxygen saturation			
		included oxygen therapy as		or per instruction on physician			
	ordered.	modulus extygen merupy as		or per mendeden en prijereid.			
				Oxygen-Nebulizer Administrat	ion		
	Review of a Physicia	n order for Resident #2		Guideline was reviewed by the			
		led if the resident was		Clinical Manager on 03/05/202	21.		
		he following symptoms		Parameters were added to the			
	_	f breathing or difficulty		on 03/05/2021 to notify MD/NI	•		
	breathing to notify the Physician.			oxygen saturation level <90%			
				increase the oxygen administr			
	Review of Resident #			maintain the oxygen saturation			
	_	ealed an order initiated on		or per instruction on physician	oraer.		
	Luo/ 13/20 Which read.	"Oxygen to be maintained				1	

STATEMENT OF DEFICIENCIES (X' AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345229	B. WING _			03/	/23/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
DEAK DE	COURCES SHELDY			1	101 NORTH MORGAN STREET			
PEAR RE	SOURCES - SHELBY			S	SHELBY, NC 28150			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 600	Continued From page	e 15	F 6	300				
	at 2-3 liters due to a l	ow oxygen saturation level."			All licensed nursing staff will be educated by the Administrator, the Director of	ed		
	Review of a nursing p	progress note dated 11/04/20			Nursing, and/or the Staff Development			
		was tested in the facility for			Coordinator regarding the following:			
		itive result via a medical lab.			3 3			
	<u>'</u>				Oxygen saturation refers to the			
	Review of Resident #	2's vital signs on 11/07/20			amount of oxygen that's in the			
	revealed the following				bloodstream. The body requires a spec	cific		
	`				amount of oxygen in the blood to funct			
	- 11/07/20 at 3:	09 AM: Oxygen saturation			properly.			
	level of 76% on 2 liter	rs of supplemental oxygen.						
	- 11/07/20 at 3:	20 AM: Oxygen saturation			2. The normal range of oxygen			
	level of 75% on 2 liter	rs of supplemental oxygen.			saturation for adults is 94 to 99 percen	t.		
		55 AM: Oxygen saturation						
		rs of supplemental oxygen.			Oxygen saturations must be			
		2:01 PM: Oxygen saturation			maintained >90%. If blood oxygen leve	ls		
	level of 66% on 4 liter	rs of supplemental oxygen.			are too low, the body may not work			
					properly. Hypoxemia can cause mild			
		ogress notes and nursing			problems such as headaches and			
	assessments dated 1				shortness of breath. In severe cases, i			
	documented assessn	nents by Nurse #3.			can interfere with heart and brain funct	ion.		
	On 02/25/20 at 8:55 A	AM an interview was			4. Oxygen administration will be			
	conducted with Nurse	e #3. She stated she was			increased to maintain oxygen level >90)%		
		ent #2 during third shift on			or as instructed by physician order.			
	11/06/20-11/7/20 from	n 11:00 PM to 7:00 AM.						
		remembered Resident #2			5. The MD/NP/PA must be notified w			
		kygen saturation level but did			oxygen saturation levels are below 909	% .		
		nad notified the Physician or						
	_	urse. She stated if she did			6. If oxygen saturations are below 90)%		
		would have been listed			and the resident presents with other			
	_	tification system called			clinical signs of respiratory distress,			
		pulled up. Nurse #3 stated			including shortness of breath, cyanosis			
	_	vas new to the facility and			elevated heart rate, and/or mental state			
	_	new nurse. The interview			changes, MD/NP/PA and EMS must be)		
		recall turning Resident #2's			notified immediately.			
		up from 2 liters during the			7			
		d her being on oxygen due			7. Comprehensive assessments are			
	ιο a diagnosis of CO\	/ID with shortness of breath.			important for all residents on oxygen			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		345229	B. WING		o:	3/23/2021	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
				1101 NORTH MORGAN STREET			
PEAK RES	SOURCES - SHELBY			SHELBY, NC 28150			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		ON SHOULD BE HE APPROPRIATE	COMPLETION DATE	
F 600	Continued From page	e 16	F 60	00			
	The interview revealed	ed she had obtained		therapy to assess for any sig	gns and		
	Resident #2's vital sig	gns on the morning of		symptoms of respiratory dist	ress.		
	11/07/20 at 3:09 AM,	3:20 AM, and 6:55 AM.					
				All residents receiving of the second s			
	Review of the facility'			will be assessed for signs ar	• •		
		f Nurse #3 notifying the		of respiratory distress every	shift or as		
	Physician of Residen levels.	t #2's low oxygen saturation		ordered by the MD/NP/PA.			
				All residents receiving of the second s			
	•	was conducted with Nurse		will have oxygen saturations			
		10 PM. She stated she		every shift or as ordered by	the		
		as using supplemental		MD/NP/PA.			
		me onto her shift and knew		40. All physician and are for			
		naintain her oxygen level		10. All physician orders for			
	greater than 90%. Sh			therapy will have parameters MD/NP/PA of oxygen satura			
		Resident #2 was short of ne on shift. The interview		90% or as instructed by MD/			
		notice that Resident #2 was		90 % of as instructed by MD/	NI /I A Oldel.		
		ss of breath or showing		The Staff Development Coo	rdinator and		
		istress and indicated the		Administrator initiated the ed			
		and her color was pink.		licensed nursing staff on 03/			
		ана негостано риши		Director of Nursing, Staff De			
	Review of the Event	report dated 11/07/20 at 4:00		Coordinator, Nursing Superv	•		
		#1 revealed Resident #2		Administrator will provide the			
	was sent to the hospi	tal due to an onset of		all licensed nurses prior to the	ne start of		
	respiratory distress.	The nurse had increased her		their next shift. Education wa	as completed		
	oxygen and notified t	he Physician. Resident #2's		on March 11, 2021. Any lice	nsed nurse		
	vital signs upon trans	fer were: Oxygen saturation		out on leave or on PRN state	us will be		
	level of 66% on 4 lite	rs of supplemental oxygen,		educated prior to returning to	o duty. Any		
	=	lood pressure 127/63 and		newly hired licensed nurse v			
	respirations 18 beats	per minute.		educated during orientation Development Coordinator.	by the Staff		
	On 02/25/21 at 9:05 /						
		e #1. She stated on 11/07/20		All Certified Nursing Assistar			
	•	for Resident #2 during the		educated by the Administrat			
		shift. The interview revealed		Director of Nursing and/or th			
		nything in report from Nurse		Development Coordinator or	-		
		nt #2's low oxygen saturation		symptoms of respiratory dist			
	levels. She stated she	e was not aware of Resident		including shortness of breatl	n, difficulty		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345229	B. WING _				23/2021
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	23/2021
	10 115211 011 001 1 21211				101 NORTH MORGAN STREET		
PEAK RES	SOURCES - SHELBY						
				5	SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	Continued From page	e 17	F	600			
	#2's low oxygen satu	ration levels until she went			breathing, cyanosis, elevated heart rate	ə.	
		om at 11:30 AM to obtain			and/or mental status changes and that		
		ed an oxygen saturation			they are required to report these signs		
	•	rs of supplemental oxygen			and symptoms to the nursing staff		
		ne stated Resident #2 was			immediately.		
	alert but lethargic due				,		
	•	stated Resident #2's color			The Staff Development Coordinator an	d	
	was good and she di	dn't appear short of breath.			Administrator will initiate the education		
	She stated you could	not tell her oxygen			all Certified Nursing Assistants on		
	saturation level was I	ow. The interview revealed			03/06/2021. The Staff Development		
	she increased Reside	ent #2's oxygen to 4 liters			Coordinator, the Director of Nursing,		
		d notified the Physician who			Nursing Supervisors, and/or the		
	gave orders to send the resident to the hospital				Administrator will provide the education		
	for an evaluation.				all Certified Nursing Assistant ☐s prior t		
					the start of their next shift. Education w	as	
		[‡] 2's hospital records dated			completed on March 11, 2021. Any		
		e was admitted from the			Certified Nursing Assistant out on leave		
		with hypoxia (deprivation of			on PRN status will be educated prior to		
		oply at the tissue level)			returning to duty. Any newly hired Cert		
	consistent with COVI				Nursing Assistant will be educated duri	ng	
		vels ranging in the 70%.			orientation by the Staff Development		
	Resident #2 was place				Coordinator.		
		once at the hospital and D-19 positive. Resident #2's			Monitoring		
		vel would not maintain above			Monitoring:		
		with a non-rebreather mask			An audit will consist of the following: O	2	
		on a bipap (machine that			saturation which is pulled from vital sig		
	pushes air into the lu				report daily. The Director of Nursing, S		
	•	s documented as diminished			Development Coordinator, and the	tan	
		n bilateral rhonchi. Resident			Nursing Supervisors will review 100%	of	
	-	is included pneumonia due			all residents on oxygen therapy daily		
	-	ilateral pneumonia and			Monday through Friday in morning clin	ical	
		h hypoxia. Resident #2 was			meeting. The Director of Nursing and/o		
	•	er evaluation and was placed			Nursing Supervisors will open and revi		
	on the medications R	•			the vital sign report in the electronic he		
		amethasone (steroid) and			record to ensure that the MD/NP/PA ha		
	,	ne was discharged on			been notified of any resident with oxyg		
		of supplemental oxygen and			saturation levels less than 90% and	ſ	
	noted to be in a stabl	e condition.			ensure that appropriate medical care h	as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345229	B. WING		0.5	C 3/23/2021	
NAME OF P	ROVIDER OR SUPPLIER	0.0220		STREET ADDRESS, CITY, STATE, ZIP CODE	0	0/23/2021	
				1101 NORTH MORGAN STREET			
PEAK RE	SOURCES - SHELBY			SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 600	conducted with the D She stated Resident on 11/07/20 and had interview revealed sh #2 experiencing an o 70% range throughor 11/07/20 and stated to been reported to the communication board she stated she could notified the Physician oxygen level. The int was new to the facilit placed off orientation was for the nurses or resident was experie and immediately noti this information was orientation for new no On 02/25/21 at 8:30 orientation for new no Conducted with the factor (NP). She stated she staff to notify her if th low oxygen saturation period of almost 9 how ould be considered would need to be add On 02/26/21 at 8:40 or conducted with the M stated he was not far however on 11/07/20 been reported to the stated they should be change in condition we	PM an interview was irector of Nursing (DON). #2 was sent to the hospital a status of full code. The was unaware of Resident exygen saturation level in the sut the early morning on those numbers should have Physician via the dimmediately. Upon review not find where Nurse #3 had a regarding Resident #2's erview revealed Nurse #3 y and may have just been and should be aware if a make a change of condition for the Physician on call and incorporated into the facility's curses. AM an interview was acility Nurse Practitioner would expect the nursing ey had a resident who had a in level of 76% to 66% for a surs. The NP stated that a change in condition and dressed immediately.	F 60	been obtained. On the weekend Nursing Supervisor will print and the vital sign report in the electrorecord to ensure that the MD/NF been notified of any resident with saturation levels less than 90% are ensure that appropriate medical been obtained. These audits will conducted daily x 2 weeks, week weeks, then monthly x 1 month. results of the audits will determined for further monitoring. QAPI The results of the audits will be the monthly QAPI meeting by the of Nursing for review and recommendations. Completion date: April 8, 2021	I review Conic health COPA has h oxygen and care has I be kly x 4 The he the		

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 _			C 03/23/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150		00/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600		e 19 extended period of time. The s expectation was for the	F 6	00		
	responsible nurse to sign, keep the reside	notice the abnormal vital nt comfortable and call the orders could be obtained,				
	07/07/20 with diagno	e-admitted into the facility on sis which included dent (CVA) and asthma.				
	Minimum Data Set (Note that the second secon	ert and oriented. Resident #1 essistance of one staff ivities of daily living (ADL). led as not receiving oxygen				
	and revised on 11/09 respiratory care due for shortness of brea	#1's care plan dated 06/16/17 1/20 revealed a focus area for to Resident #1 being at risk th related to a history of ion included notifying the s of breath occurred.				
	dated 07/30/20 reveal experiencing any of the	n order for Resident #1 aled if the resident was he following symptoms of breathing or difficulty e Physician.				
		‡1's nursing progress note aled she was diagnosed with te.				
		t1's November 2020 rders for oxygen/ respiratory nurses could place residents				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING	, ,	(X3) DATE SURVEY COMPLETED				
		345229	B. WING			C
	ROVIDER OR SUPPLIER	0.0020		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	I	03/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	oxygen saturation le how many liters of or Review of a nursing at 3:54 PM written if #1's Responsible P stated Resident #1 Nurse #1 checked of an oxygen saturation 92-100%). The note oxygen at 4 liters possible with a liters possible pos	cygen as needed for a low evel. The order did not specify	F 60	·		
	Resident #1's room around 2:00 PM sho room to find her in t	tnow if Nurse #1 went into to check on her. She stated e went back into Resident #1's he same condition continuing y breathing so she notified				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_ ` ´	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345229	B. WING			C
	ROVIDER OR SUPPLIER	343223		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	l	03/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	#1's responsible par well and notified her breath. When Nurse obtain an oxygen sa was in the 70% rang stated Nurse #1 the an oxygen concentr. Resident #1 via a na revealed after Nurse Resident #1 she still the oxygen tubing cardrop. On 02/24/21 at 10:0 conducted with Nurse was responsible 7:00 AM to 7:00 PM had received a phor responsible party ar was experiencing shaded oxygen. She #1 coming to her an with Resident #1 ho she may have forgo went into the resident the phone and check low reading. The into the resident #1 so improved. Nurse #1 call from Resident #1's o improved. Nurse #1 call from Resident # stating the resident # stating the resident # shortness of breath When she entered to have her oxygen on level was low again.	e interview revealed Resident ty had called Nurse #1 as of Resident #1's shortness of #1 entered the room to turation level NA #1 stated it ge (normal 92-100%). She in ran down the hall to obtain ator and applied oxygen to asal cannula. The interview if applied oxygen to seemed confused removing ausing her oxygen level to 7 AM an interview was if #1. She stated on 11/07/20 if for Resident #1 during the shift. Nurse #1 stated she if call from Resident #1's bound 3:30 PM who said she inortness of breath and if stated she did not recall NA id saying anything was wrong wever it had been a while and itten. Nurse #1 stated she int's room with the RP still on ked her oxygen level to find a perview revealed she ran from to get an oxygen concentrator via nasal cannula at 4 liters ity gen saturation level stated she received a second 1's RP around 4:30 PM was still experiencing and to go and check on her. The room Resident #1 did not and her oxygen saturation She stated she placed the into Resident #1's nose and	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345229	B. WING		C 03/23/2021
	ROVIDER OR SUPPLIER SOURCES - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	03/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 600	revealed she passe second shift nurse of did not notify a Physiof condition requirin stated she did not fethe resident's oxyger liters. On 02/24/21 at 10:2 conducted with Nursesponsible for Resident's oxyger the 7:00 PM to 7:00 she had received rethe interview she staduring shift change experienced a chan supplemental oxyger had not worn oxyger interview revealed Fernaround 8:30 PM medication pass stated to the hospital interview revealed started her medication Resident #1's room	treased to 90%. The interview of the information along to the during shift change however sician of Resident #1's change g supplemental oxygen. She seel like she needed to since en level had increased on 4 O AM an interview was see #2. She stated she was ident #1 on 11/07/20 during AM shift. Nurse #2 stated sport from Nurse #1. During ated she was not informed that Resident #1 had ge requiring the need for en. She stated Resident #1 in prior to that day. The Resident #1's RP had called I during the middle of her uting he wanted Resident #1 for an evaluation. The she had received report and ion pass not making it to yet. Nurse #2 stated she went	F 60	,	
	respiratory distress. signs and they were did not chart them at they were. She notif (DON) who was in the Practitioner on call. ordered a nebulizer needed and a chest NP told her if the fail Medical Services the resident was in no resident was in the province of the province was in the province of the province	soom to find her in no She stated she obtained vital within normal limits however and could not remember what fied the Director of Nursing he building and the Nurse The Nurse Practitioner treatment every 4 hours as x-ray. Nurse #2 stated the mily wanted to call Emergency ey could however if the espiratory distress, she didn't did them out. She stated the			

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345229	B. WING		C 03/23/2021	
	ROVIDER OR SUPPLIER SOURCES - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	03/23/2021	
(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 CROSS-REFERENCED TO THE APPROP) BE COMPLÉTION	
F 600	(EMS) and Resident is hospital at 9:30 PM. Review of the Nurse computerized community of the Nurse of the residents Responsible of the residents Responsible of the resident of the Nurse of the Nurse of the Nurse of the resident of the Nurse of the resident of the nurse of the resident of the nurse of t	Practitioner (NP) nication board revealed on urse #2 notified the on-call son was requesting she go evaluation. Nurse #2 wrote nt #1 was in no distress but sible Party (RP) would feel The note revealed ng her nasal cannula out of ed her oxygen level to drop led the cannula in place on the NP gave orders to obtain and nebulizer treatments as of breath and wheezing but the hospitalization was ad if the family wanted the lospital, they could call ervices (EMS). AM an interview was lent #1's Responsible Party view he stated he had	F 60			

AND DUAN OF CODDECTION DENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION IG	(X3)	(X3) DATE SURVEY COMPLETED	
		345229	B. WING _			C
	ROVIDER OR SUPPLIER	040220		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	l	03/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 600	when the nurse went was in fact not wear the oxygen back into oxygen level increas called back, he spothow Resident #1 was he hadn't been into check on her. The Feather wanted Resident #1 evaluation. The intervaluation in the Director of Nursing who both recommer to the hospital becar respiratory distress wanted her sent to the Emergency Medical which he did. On 02/24/21 at 12:3 conducted with the During the interview a full code and if the the nurse was responsible to the nurse was responsible to the hospital but that resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no restated she did not go but told Nurse #2 to the resident was in no resta	dent #1 had said. He stated to into the room the resident ing her oxygen, she placed of Resident #1's nose and her sed. The RP stated when he se with Nurse #2 and asked is doing. She stated to him the room yet, but she would the stated he told Nurse #2 he sent to the hospital for an exiew revealed Nurse #2 stated she had spoken with ing and Nurse Practitioner and that time. He was told if he he hospital, he could call Services (EMS) himself in 19 PM an interview was Director of Nursing (DON). She stated Resident #1 was re was a change of condition insible for notifying the left. She stated she was in the working on another hall during a stated Nurse #2 had come of wanted Resident #1 sent to her assessment was the espiratory distress. The DON of assess the resident herself just let the Physician know no respiratory distress.	F6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345229	B. WING _			C 03/23/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	<u> </u>	03/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	additional history wh Room and her responsiformation. Resident hospital were temperablood pressure 127/5 level of 92% on 4 liter plan for Resident #1 (blood thinner) for treembolism and to initi (steroid). On 11/10/2 emergently at the becovernight she had extraction to Covid-19 fevers and more showas intubated and plunit (ICU). Resident were in the 70% 's. Resident #1's RP to comfort care. On 02/25/21 at 8:30 conducted with the factory of the stated she staff to notify her if the previously did not reconsupplemental oxysaturation level in the that would be considered and would need to be on 02/24/21 at 10:20 conducted with the Notated when he reviet 11/07/21 he saw the requested Resident an evaluation despite that the resident was	lethargic to give any en seen in the Emergency nsible party had given the t #1's vital signs at the rature 102, heart rate 95, 52 and oxygen saturation ers of oxygen. The treatment included low dose heparin eatment of the pulmonary ate her on Dexamethasone 1 Resident #1 was seen dside for acute hypoxia, experienced an increased Pneumonia with spiking rtness of breath. Resident #1 acced in the Intensive Care #1's oxygen saturation levels A discussion was had with transition the resident into AM an interview was acility Nurse Practitioner would expect the nursing they had a resident who equire oxygen therapy, placed gen due to a low oxygen to 70 % range. The NP stated there a change in condition the addressed immediately. I AM an interview was Medical Director (MD). He they was the seed to the hospital for the the nurse's assessment to experiencing no respiratory the hypoxia (the absence of	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345229	B. WING _			C 03/23/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	'	3012012021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R 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 600	function) did not equinterview revealed has for respiratory distressory muscle dike Resident #1 was oxygen saturation lessupplemental oxygenoted to be confused did not have the mesupplemental oxygeshe was removing it ordered a nebulizer when Nurse #2 notified the summary of the wasn't in the buildidecision and if a resident go to the told it was their right services. The interview protocol to place resident was diagonal pneumonia at the heembolism which coushe had been sent to than she was. The interview of the resident services was diagonal to the membolism which coushe had been sent to than she was. The interview of the resident services was diagonal to the resident services.	ne tissue to sustain bodily ual respiratory distress. The ne did not send residents out ess unless they were in active distress which it did not seem s in as evidenced by her	F 6	· · · · · · · · · · · · · · · · · · ·		
	with her oxygen sati threw a clot and end embolism. He stated could have known the The facility Administ immediate jeopardy	uration improving yet still ded up with a pulmonary d there was no way the facility hat was occurring. trator was notified of the on 03/05/21 at 9:06 AM. rator was notified of an of immediate jeopardy on				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345229	B. WING _			C 03/23/2021
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	'	00/20/2021
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	Continued From pag	e 27	F 6	00		
		the following credible ate Jeopardy removal:				
	_	cipients who have suffered, , a serious adverse outcome ncompliance:				
	11/04/2020. Resider supplemental oxyge maintain oxygen sat on 08/13/2020. On 1 #2 oxygen saturation on 2 liters of suppler at 3:20 AM Resident documented to be 75 supplemental oxygen	n. On 11/07/20 at 6:55 AM				
	to be 75% on 2 liters Nurse #3 did not not physician/nurse prac (MD/NP/PA) of the lo nor did Nurse #3 inc	ctitioner or physician assistant ow oxygen saturation levels rease Resident #2 oxygen as				
	Nurse #3. On 11/07/ noted that Resident 62%. Oxygen was be per minute. Nurse # oxygen to 4 liters pe resident's physician.	MD. There is no the resident was assessed by 20 at 11:30 AM, Nurse #1 #2 oxygen saturation was eing administered at 2 liters 1 increased the resident's r minute and notified the Resident #2 was transferred om for evaluation and				
	failure of Nurse #3 to desaturations were I	npliance resulted from the o identify that the oxygen ife threatening, to assess the ease Resident #2's oxygen				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	' '	(X3) DATE SURVEY COMPLETED	
		345229	B. WING _			C 03/23/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	.	03/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	of the life-threatening delayed Resident #2 attention. Nurse #3 or reported the desature the oncoming nurse Resident #2 was adr 11/07/2020 with hypothe hospital and substacility on 11/13/2020 for Bilateral Pneumovirus. While hospitalinasal cannula and re (broad-spectrum ant Dexamethasone (colimproved and upon reliters per minute via 2. Resident #1 was re 07/07/20 with diagnoderebrovascular acceptants and stated Resident Wurse #1 in Resident #1 's Respected Nurse #1 in minute (1pm) and Resident work with the progress of the nursing progress 4:41 PM written by Negone into Resident # cannula tubing on the of in her nose. Resident # cannula into Resider Resident was at 70%. No cannula into Resider	y not notifying the MD/NP/PA g situation. These failures from getting medical could not recall if she ations to the MD/NP/PA or on 11/07/2020. mitted to the hospital on oxia. Resident was treated at sequently returned to the of for care post hospitalization nia secondary to Covid-19 zed, she required high-flow exceived Remdesivir iviral medication) and rticosteroid). She steadily return required oxygen at 1-2 nasal cannula. e-admitted into the facility on esis which included dent (CVA), anxiety and of at 3:54 PM, Nurse #1 esident progress notes that onsible Party (RP) had called #1 sounded short of breath. In Resident #1 to find she had in level of 72%. The note uitiated oxygen at 4 liters per esident #1's oxygen level	F 6			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345229	B. WING _			C 03/23/2021
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 1101 NORTH MORGAN STR SHELBY, NC 28150		33/23/23/21
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	((EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD BI CED TO THE APPROPRIA EFICIENCY)	
F 600	(MD/NP/PA) of the si saturation levels nor physician/nurse pracchange of condition in oxygen. On 11/07/2020 at 8:3 that Resident #1's R PM during the middle stating he wanted Refor an evaluation. Nu informed during shift had experienced a ci supplemental oxyger into Resident #1's ror respiratory distress. signs and they were she did not chart the remember what they Director of Nursing (I building and the Nurse Practitioner or every 4 hours as need Nurse #2 stated the wanted to call Emergical them out. She send them out. She semergency Medical Resident #1 was trang:30 PM.	fy Resident #2 titioner or physician assistant udden onset of low oxygen did Nurse #1 notify the titioner of Resident #1's requiring supplemental 80 PM, Nurse #2 revealed P had called her around 8:30 e of her medication pass esident #1 sent to the hospital rse #2 stated she was not change that Resident #1 hange requiring the need for n. Nurse #2 stated she went om to find her in no She stated she obtained vital within normal limits however, m and couldn't not were. She notified the DON) who was in the se Practitioner on call. The dered a nebulizer treatment eded and a chest x-ray. NP told her if the family gency Medical Services they resident was in no she didn't see the need to stated the RP contacted	F	500		
	10:00 PM revealed to	nat Resident #1 had a 9 pneumonia and pulmonary				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345229	B. WING		C 03/23/2021	
	ROVIDER OR SUPPLIER SOURCES - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	, 33/10/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION	
F 600	embolism. Resident facility. The alleged non-co failure of Nurse #1 to desaturations were Resident #1, and by of the life-threatenir delayed Resident # attention. An audit was comple 03/05/2021. The Acresidents who are concluded in the life was received oxygeto determine if any oxygen desaturation notified and appropaddition, all physicial administration were orders had paramet MD/NP/PA. All physicial modified and propaddition, all physicial administration were orders had parameter orders had parameter however, no additional potenthowever, no additional potenthowever, no additional potenthowever, no additional potenthowever, and the practice. All 17 resignarameters of notificial oxygen saturations #2. Specify the action will not process or system adverse outcome from the action will nurse #3 was eductions.	mpliance resulted from the to identify that the oxygen life threatening, to assess the rot notifying the MD/NP/PA ag situation. These failures 1 from getting medical eted by the Administrator on Iministrator reviewed all urrently on oxygen therapy or en therapy in the last 72 hours other resident had episodes of an and if so, was the MD/NP/PA riate interventions applied. In an orders for oxygen reviewed to ensure that all ters for notification of sician orders state to notify the en saturations <90% and to turations >90%. There were stally affected residents, and residents were identified ceted by the alleged deficient dents had orders for cation. No resident had <90%. On the entity will take to alter em failure to prevent a serious om occurring or recurring, and be complete. ated by the Director of 021 regarding the importance	F 60			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345229	B. WING		03/23/2021
	ROVIDER OR SUPPLIER SOURCES - SHELBY	1 0.022		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150	03/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 600	and to increase the omaintain the oxygen instruction on physic Oxygen-Nebulizer Arreviewed by the Reg 03/05/2021. Parame guideline on 03/05/2 any oxygen saturation the oxygen administration level >90% physician order. All licensed nursing and Administrator, the Distaff Development Of following: 1. Oxygen saturation oxygen that's in the Irrequires a specific at to function properly. 2. The normal range adults is 94 to 99 per 3. Oxygen saturation If blood oxygen level not work properly. Hyproblems such as he breath. In severe cas and brain function. 4. Oxygen administramaintain oxygen level physician order.	oxygen administration to saturation level >90% or per ian order. Idministration Guideline was ional Clinical Manager on ters were added to the 021 to notify MD/NP/PA of on level <90% and to increase ration to maintain the oxygen of or per instruction on Staff will be educated by the rector of Nursing, and/or the coordinator regarding the coordinator regarding the coordinator of oxygen in the blood of oxygen saturation for recent. Is must be maintained >90%. Is are too low, the body may be adaches and shortness of sees, it can interfere with heart of the polocytes of a sees, it can interfere with heart of the polocytes of a see instructed by the saturation of oxygen will be increased to the polocytes of a sinstructed by the saturation to oxygen will be increased to the polocytes of a sinstructed by the saturation of oxygen will be increased to the polocytes of a sinstructed by the saturation of oxygen will be increased to the polocytes of th	F 60		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
						С		
		345229	B. WING			03/	23/2021	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
PEAK RES	SOURCES - SHELBY				SHELBY, NC 28150			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 600	Continued From page	≥ 32	F	600				
	resident presents with respiratory distress, in cyanosis, elevated he	ns are below 90% and the n other clinical signs of ncluding shortness of breath, eart rate, and/or mental NP/PA and EMS must be						
	all residents on oxyge	sessments are important for en therapy to assess for any of respiratory distress.						
		ring oxygen therapy will be nd symptoms of respiratory as ordered by the						
		ring oxygen therapy will have conitored every shift or as P/PA.						
	have parameters to n	ers for oxygen therapy will otify the MD/NP/PA of ss than 90% or as instructed						
	licensed nurses prior shift. Any licensed nu status will be educate The Director of Nursin tracking staff that hav education. The Staff I	If the education for all for 0.03/05/2021. The staff Development Supervisors and/or vide the education to all to the start of their next rese out on leave or on PRN and prior to returning to duty.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345229	B. WING _			C 03/23/2021
	ROVIDER OR SUPPLIER SOURCES - SHELBY			STREET ADDRESS, CITY, STATE, ZIP CODE 1101 NORTH MORGAN STREET SHELBY, NC 28150		30,20,202
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	by the Administrator nurse will be educated. All Certified Nursing by the Administrator and/or the Staff Devisigns and symptoms including shortness cyanosis, elevated histatus changes and report these signs a staff immediately. The Staff Development of Certified Nursing Asstaff Development of Nursing, Nursing Staff Development of Nursing, Nursing Staff Development of Nursing, Nursing Staff Development of Nursing Supervisors Coordinator were not of Staff Development of Nursing Supervisors Coordinator were not of Staff Development of Nursing Staff Development of	responsibility on 03/05/2021 c. Any newly hired licensed and during orientation. Assistants will be educated and the Director of Nursing relopment Coordinator on a for espiratory distress, of breath, difficulty breathing, the present and read that they are required to and symptoms to the nursing that they are required to and symptoms to the nursing that the education for all assistants on 03/06/2021. The Coordinator, the Director of apervisors, and/or the ovide the education to all assistant 's prior to the start of Certified Nursing Assistant PRN status will be educated duty. The Director of Nursing or tracking staff that have not ion. The Director of Nursing or tracking staff that have not ion. The Director of Nursing, and Staff Development of this responsibility on administrator. Any newly hired assistant will be educated ducated the Director of Iopment Coordinator, and the son 03/05/2021 that all an therapy will be reviewed gh Friday in morning clinical or of Nursing and/or Nursing and review the vital sign	F 6			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345229	B. WING				23/2021
	PEAK RESOURCES - SHELBY			1	STREET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH MORGAN STREET SHELBY, NC 28150		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	that the MD/NP/PA haresident with oxygen 90% and ensure that has been obtained. Osupervisor will print a report in the electronic that the MD/NP/PA haresident with oxygen 90% and ensure that has been obtained. The Director of Nursin Coordinator for review TITLE OF THE PERSIMPLEMENTING THIFOR IMMEDIATE JE The Administrator and be ultimately responsimplementation of creating alleged immediate. Immediate Jeopardy On 03/11/21, the facil immediate Jeopardy review of documentation of the importance of contifying the provider level <90% and increate to maintain the oxygen per physician instruct revealed receipt of training of oxygen satur administration to keep notifying the provider	chealth record to ensure as been notified of any saturation levels less than appropriate medical care on the weekend, the Nursing and review the vital sign to health record to ensure as been notified of any saturation levels less than appropriate medical care these reports will be given to a gand/or Staff Development w. SON RESPONSIBLE FOR E CREDIBLE ALLEGATION OPARDY REMOVAL. If the Director of Nursing will sible to ensure the edible allegation to remove the jeopardy. Removal Date: 03/06/2021 Itity's credible allegation of the emoval was validated by the ton regarding staff training boxygen saturation readings, of any oxygen saturation asing oxygen administration on saturation level >90% or the control of the importance of the ration >90%, oxygen	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		345229	B. WING _			C 03/23/2021
	ROVIDER OR SUPPLIER SOURCES - SHELBY	1 0.0220		STREET ADDRESS, CITY, STATE, ZIP COI 1101 NORTH MORGAN STREET SHELBY, NC 28150	DE	03/23/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 600	therapy every shift for respiratory distress, in of residents receiving and ensuring physicial administration have provider of an oxyge.	or signs and symptoms of monitoring the oxygen level g oxygen therapy every shift,	F6	500		