STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 02/24/2025 through 02/28/2025. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # JV7H11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/24/25 through 02/28/25. Event ID JV7H11. The following intakes were investigated NC00215519, NC00216102, NC00216529, NC00221052, NC00217927, and NC00222888. 24 of the 24 allegations did not result in a deficiency.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or	F 580		3/25/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 03/25/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 1 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident and physician interviews, the facility failed to notify the physician when a dental service consultation for a tooth extraction was not able to be scheduled for 1 of 1 resident (Resident #32) reviewed for dental services.	F 580	F580 Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 2 The findings included: Resident #32 was admitted to the facility on 3/5/24. Her diagnosis included exfoliation of teeth (process that allows the replacement of the primary dentition with permanent teeth) due to systemic causes, disorientation, hypertensive heart disease, chronic kidney disease, chronic diastolic (congestive) heart failure and periapical abscess without sinus (a dental abscess that occurs when bacteria infects the tooth's root and doesn't drain into a sinus). A quarterly MDS dated 11/24/24 revealed Resident #32 was cognitively intact. Resident #32 had no mouth pain, facial pain or difficulty chewing. A consultation/report letter dated 12/5/24 stated Resident #32 was seen in the dental office/oral surgeon for a consultation. Resident #32 was not a candidate for treatment to be done in the office setting. Resident #32 would need to be treated in a hospital setting. The recommendations stated that due to the health history of Resident #32 she was not a candidate for intravenous (IV) sedation in an outpatient setting. Resident #32 was referred back to the dentist to send to a hospital setting for the procedure to be completed. This note was signed by the Unit Manager who documented the consultation report was faxed to the contracted mobile Dentist on 12/6/25. The facility's facsimile cover page dated 1/22/25 indicated a referral for Resident #32 to be seen by an outside dental agency. The facsimile documented: please call the Unit Manager to schedule an appointment or if you have any	F 580	requirements and to continue to provide high quality care. Resident Affected Resident # 32 had tooth extraction completed on 3/20/2025. Resident did not suffer any sustained adverse effect related to the alleged deficient practice. Other Residents with potential to be affected All residents receiving in-house dental services have the potential to be affected. An audit was completed by the Social worker on 3/25/2025 of the last three months of dental consults to ensure that the physician was notified of any dental procedures that could not be completed in house and required outside consultation. There were no additional issues identified. No residents suffered any adverse effect related to the alleged deficient practice. Systemic changes The Administrator educated the Registered Nurse Supervisor and the Social Worker that the physician must be notified of any dental procedures that could not be performed in-house and required outside consultation. This was completed on 3/24/2025. This education is part of the orientation process for social workers and RN Nurse Supervisors. Monitoring The Administrator, Director of Nursing, RN supervisor or Licensed Practical Nurse in charge will audit 5 residents weekly times four weeks, (on random	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 3 questions, and that the resident required sedation. An interview with the Unit Manager on 2/27/25 at 11:28AM revealed consultation reports following an appointment would come to her either by fax or upon return from an appointment and she reviewed the consultations for further recommendations. She stated the oral surgeon recommendations dated 12/5/24 stated they could not perform the procedure (tooth extraction) on Resident #32 because they could not sedate her for the procedure. She stated following the recommendations from the oral surgeon on 12/5/24, she completed a referral for Resident #32 to be seen by a dental school on 1/22/25. The Unit Manager stated she was unsure of why she had not sent the referral to the dental school school before 1/22/25. During the interview, the Unit Manager was observed to review her emails. She stated she had not received confirmation that Resident #32 could be seen by the dental school for the extraction. She revealed she had not followed up with the dental school to determine if the procedure could be completed per the referral she completed (1/22/25). The Unit Manager indicated she should have followed up on the referral she sent to determine if Resident #32 could have an extraction at their office. During an interview with Resident #32 on 2/25/25 at 12:35pm, Resident #32 indicated she had to have her tooth extracted because she had some tooth pain. In an interview with the contracted mobile Dentist on 2/27/25 at 2:15pm he revealed he completed his initial exam on Resident #32 on 10/22/24. He recalled Resident #32 having sensitivity of a	F 580	halls to include all halls), then biweekly x 4 weeks, then monthly x 1 month to ensure that the physician is notified of any dental procedures that were not performed in-house and required outside consultation. This audit will be documented on the dental audit tool. The results of these audits will determine the need for further monitoring. QAPI The results of the monitoring tool will be brought to the monthly Quality Assurance and Performance Improvement Committee times three months by the DON for further review and recommendations. Completion date: March 25, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 4 crown on the lower left side of her mouth. With tapping and percussion Resident #32 had a little bit of pain. Resident #32 had said her previous exam (prior to admission to the facility) indicated she needed an extraction. Resident #32 was apprehensive of needles which was the reason he referred Resident #32 to have an extraction of tooth #19 with the oral surgeon. The oral surgeon could do deep sedation for dental procedures. In an interview with the Physician on 2/28/25 at 9:58AM she revealed the oral surgeon felt Resident #32 needed general anesthesia to have her tooth extracted. It could be difficult to locate a dentist to do general anesthesia on Resident #32 due to her health condition from a cardiology standpoint. If the facility was unable to find an inpatient facility to do the dental procedure under general anesthesia, the facility should have made her aware so she could attempt to locate an alternative. She further stated Resident #32 was clinically stable and had no complaints regarding tooth pain prior to her appointment with the oral surgeon or thereafter. The facility needed to figure out how to take care of the resident's extraction but not in an emergency setting. The Physician stated she would need to talk with the nurse and Social Worker to identify a plan.	F 580		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5	F 623		

language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 6	F 623		

(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 7 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the resident/Responsible Party (RP) in writing regarding the reason for transfer to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #70). Findings included: Resident #70 was admitted on 12/23/24. His diagnoses included Type 2 diabetes mellitus with foot ulcer. Resident #70's admission Minimum Data Set dated 12/27/24 indicated he was cognitively intact. Nursing documentation dated 1/03/25 at 2:10 PM indicated Resident #70 had been aware of his need to be transferred to the Emergency Room for evaluation. Messages had been left for his first and second contacts to call the facility regarding Resident #70. Resident #70 had been discharged to the hospital for an acute condition on 1/3/25. Record review did not reveal evidence of the discharge/transfer notice had been sent to	F 623	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 8	F 623		

Resident #70 or his Responsible Party (RP). Resident #70 did not return to the facility.

On 2/27/25 at 5:31 PM an interview with the Business Office Manager (BOM) was conducted. She indicated she was responsible for the discharge/transfer notice and stated she had missed providing this to Resident #70 or his RP. She explained the Regional Business Office Manager had conducted an audit and discovered this had been missing.

On 2/27/25 at 5:28 PM an interview was conducted with the Administrator. He stated the notice of transfer should be provided to the resident and/or RP.

The facility provided the following corrective action plan with a completion date of 1/28/25.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

On 1/27/25 an audit was conducted by the Corporate BOM and her audit revealed that six (6) residents were noted to not have the discharge process noted in resident notes in the electronic health record (EHR) (noting Resident #70 was one of the identified residents). Families were not called, noted and/or issued a notice of transfer via mail while the BOM was out. These residents did not suffer any adverse effects related to the alleged deficient practice. Completed dated 1/27/2025

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 9	F 623		

All residents have the potential to be affected by the alleged deficient practice. On 1/27/2025 facility reviewed all discharges from the past (7) seven days and no residents were affected related to the deficient practice.
Completed date 1/27/25

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

On 1/27/2025 the Administrator provided education to the BOM and SW (Social Worker) pertaining to the documentation of resident notification of transfer/discharge from the facility. The SW, Administrator and /or designee will provide back-ups for the BOM when not at work. Moving forward it will be mailed, a phone call will be made and noted according to policy by the Business Office Manager, Social Services Director, Administrator, and /or designee. Any newly hired BOM, SW, DON and/or Administrator will be educated on this process during orientation.
Completed date 1/27/25

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

All discharges will be reviewed in the daily clinical meeting to ensure documentation of notification of discharge/bed hold is noted in EHR. Administrator/designee will audit monthly X (times) 3 months the discharge notification process to ensure all parties are notified according to policy. The results of these audits will be brought to the QAPI (Quality Assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 10 and Performance Improvement) committee monthly X 3 months by the Administrator for review and further recommendations. Completed date 1/27/25 Include dates when corrective action will be completed: 1/28/25. Onsite validation of the corrective action plan was completed on 2/28/25. The initial 1/27/25 audit was verified. Evidence of an in-service on 1/27/25 given by the Administrator included the DON, BOM, and the Social Worker (SW). Interviews with the DON, BOM and SW verified they received in-service training on documentation of discharge from the facility and the resident discharge summary. Evidence of discharge and written notification monitoring was observed. The compliance date of 1/28/25 for the corrective action plan was validated.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;	F 625		3/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 11 (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notification of the bed hold policy when a resident was transferred to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #70). Findings included: Resident #70 was admitted on 12/23/24. His diagnoses included Type 2 diabetes mellitus with foot ulcer. Resident #70's admission Minimum Data Set dated 12/27/24 indicated he was cognitively intact. Nursing documentation dated 1/03/25 at 2:10 PM indicated Resident #70 had been aware of his need to be transferred to the Emergency Room for evaluation. Messages had been left for his first and second contacts to call the facility regarding Resident #70. Resident #70 had been discharged to the hospital	F 625	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F 625 Resident Affected by the Deficiency Resident #70 did not return to the facility. There was documentation that a copy of the bed hold policy was provided to the resident upon transfer to the hospital on 01/03/2025. Other residents with potential to be affected On 03/21/2025, the Director of Nursing reviewed all residents who were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 12 for an acute condition on 1/3/25. Record review did not reveal evidence that the bed hold policy had been sent with Resident #70 when he unexpectedly discharged to the hospital on 1/3/25. Resident #70 did not return to the facility. An interview with Resident #70 was conducted via phone on 2/27/25 at 3:12 PM. He stated he had been in the hospital for about a week. When he was ready to discharge, he was told there were no beds available at this facility and was discharged to another rehabilitation facility. He stated he would have returned to this facility if a bed had been available. On 2/26/25 at 8:07 AM an interview with the Director of Nursing (DON) was conducted. She stated the nurses' print copies of the bed hold policy along with the transfer form and other information to send to the hospital. She stated this was not usually documented anywhere. An interview was conducted with Nurse #3 on 2/27/25 at 1:17 PM. Nurse #3 stated when a resident discharged to the hospital their demographic information, list of medications, diagnoses, emergency contact and code status information was sent with the resident. When asked about the bed hold policy Nurse #3 stated that it was usually sent but sometimes, they ran out of copies. On 2/27/25 at 5:31 PM an interview with the Business Office Manager (BOM) was conducted. She stated that the bed hold policy was not sent to Resident #70 or his Responsible Party (RP). She explained she usually sent the bed hold	F 625	transferred to the hospital from 02/25/2025 to 03/21/2025 to ensure that there was documentation that written notification of the bed hold policy was provided to the resident/resident representative. There were no additional issues identified. No resident suffered any adverse effects related to the alleged deficient practice. Systemic Changes: On 3/25/2025, the DON educated all licensed nursing staff that when a resident is transferred to the hospital a copy of the bed hold policy will be sent with the resident when transferred to the hospital. Any licensed nursing staff out on leave or PRN status will be educated on this process by the Staff Development Coordinator or DON prior to returning to duty. This process is part of the education provided to all newly hired licensed nursing staff during orientation by SDC/DON. Monitoring An audit tool was developed to monitor for compliance with this plan of correction. Nursing administration will audit all hospital transfers daily in morning clinical meeting Monday through Friday to ensure that the hospital transfer event was completed, and documentation was checked that the bed hold policy was sent with the resident. All discharge events will be audited weekly x 4 weeks, then bi-weekly x 4 weeks then monthly x 1 month. Any issues will be addressed immediately at the time of identification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 13 policy with the hospital information and would follow up with a phone call to the RP. She explained she had been off the day Resident #70 had been sent to the hospital, and she failed to follow up with the RP about the bed hold policy or mail the information. She explained the Regional Business Office Manager had conducted an audit and discovered her follow-up had been missing. On 2/27/25 at 5:28 PM an interview was conducted with the Administrator. He stated he was unaware of needing to allow a discharged resident to return to the first available bed when none were available at the time of their discharge from the hospital.	F 625	The results of these audits will determine the need for further monitoring. QAPI The results will be brought to the monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting monthly x 3 months by the DON for review and further recommendations. Completion date: 3/25/25	
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of	F 626		3/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 14 returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to allow a resident to return to the facility after hospitalization for 1 of 1 resident reviewed for hospitalization (Resident #70). Findings included: Resident #70 was admitted on 12/23/24. Resident #70's admission Minimum Data Set dated 12/27/24 indicated he was cognitively intact. His diagnoses included type 2 diabetes mellitus with foot ulcer and cellulitis of the right lower extremity. Resident #70 was transferred to the hospital for an acute condition on 1/3/25. Resident #70's hospital discharge summary dated 1/16/25 indicated the hospital case manager had noted [transferring facility name] had been Resident #70's long term care rehabilitation facility preference. The note	F 626	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F626 Resident affected by this deficiency: Resident was notified of transfer/ bed hold policy upon transfer to the hospital. There is documentation that a copy of the bed hold policy was provided to resident #70 per discharge event on 1/3/2025. There were no adverse effects to the resident from the alleged deficient practice. Resident #70 was discharged from the facility on 1/03/2025 and did not return.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 15 indicated there had been no availability and Resident #70 had been discharged to another facility. An interview with Resident #70 was conducted via phone on 2/27/25 at 3:12 PM. He stated he had been in the hospital for about a week. When he was ready to discharge, he was told there were no beds available at [transferring facility name] and was discharged to another rehabilitation facility. He stated he would have returned to [transferring facility name] if a bed had been available. An interview with the Admissions Coordinator was conducted on 2/27/25 at 4:13 PM. She explained the bed hold policy had not been given to Resident #70 or his Responsible Party (RP) when he was discharged. She stated most of the time she spoke with the hospital case worker about bed availability and explained it probably was her who had said there were no beds available. She stated Resident #70 would have been allowed to return if a bed had been available. The Admissions Coordinator provided the facility census for 1/16/25 which revealed only one semiprivate female bed was available that day. The Admissions Coordinator explained she had not offered Resident #70 a bed when one became available. On 2/27/25 at 5:28 PM an interview was conducted with the Administrator. He stated he had been unaware of allowing residents to return to the first available bed when no beds were available at the time of discharge from the hospital. Messages were left for the Case Manager at the	F 626	Residents with potential to be affected: On 3/25/2025, a 100% audit of hospital transfers from 2/25/2025 through 3/21/2025 was conducted by the Administrator to ensure that all residents that were transferred to hospital were provided with the bed hold policy and received notification of bed availability, if there weren't any available beds upon return to facility. No other residents suffered any adverse effect from the alleged deficient practice. Systemic Changes: On 3/25/2025, the Administrator educated the Business Office Manager and/or designee that when a resident is transferred to the hospital and a bed is not available upon return, that the facility is required to notify the resident/RP upon bed availability, according to the transfer and bed hold policy. Monitoring An audit tool was developed to monitor for compliance with this plan of correction. The administrator and/or DON will audit all hospital transfers daily in morning clinical meeting Monday through Friday of the prior 24 hours and Monday from the weekend to ensure that the hospital transfer event was completed, documentation was checked that the bed holds policy was sent with resident and bed availability notification was given for the next available bed, if a bed was unavailable upon return. This will be done daily x 3 months, then ongoing as part of standard practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 16 discharging hospital on 2/27/25 and 2/28/25 with no return call received.	F 626	QAPI The results of these audits will determine the need for further monitoring. All results will be brought to the monthly Quality Assurance and Performance Improvement Committee (QAPI) meeting monthly x 3 months by the DON for review and further recommendations. Completion date: 3/25/2025	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		3/24/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop an individualized person-centered care plan in the areas of pain management, anticoagulant and diuretic use, and behaviors for 3 of 6 residents reviewed for comprehensive care plans (Resident #32, #21 and #63). The findings included: 1. Resident # 32 was admitted to the facility on 3/5/24 with a diagnosis that included pain. Review of Resident #32 comprehensive care plan dated 11/21/24 did not reveal a care plan for pain. Review of Resident #32's physician orders dated	F 656	F656 The preparation and execution of this plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and provide high quality of care. Resident affected Resident #32 careplan was revised to include a careplan for pain on 2/27/2025 by Jennifer Clapp, LPN Minimum Data Set Nurse (MDS). Resident #32 did not suffer any adverse effects related to alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 11/21/24 stated Oxycodone 5 milligrams (mg) as needed for breakthrough pain, Oxycodone 5mg every 8 hours for pain, Gabapentin 300 mg at bedtime for pain and Gabapentin 600mg 2 times a day for pain. The quarterly Minimum Data Set (MDS) assessment dated 11/24/24 revealed Resident # 32 was cognitively intact and was administered pain medication. The pain medication was scheduled and as needed (PRN). Interview with MDS Coordinator #1 on 2/27/25 at 4:29 PM revealed she participated in clinical meetings every morning. During clinical meetings, updates to resident medications were discussed and reviewed which was how she was kept abreast of care planning needs. She stated Resident #32 should have had a care planned for developed for pain due to receiving oxycodone and gabapentin. She indicated she did not develop a comprehensive care plan due to her oversight. Interview with the Director of Nursing (DON) on 2/27/25 at 5:27 PM stated Resident #32 was prescribed scheduled and PRN medications for pain. Medications were reviewed in clinical meetings every morning to include the MDS coordinator. She stated there should have been a care plan developed for Resident #32's pain. 2. Resident #63 was initially admitted to the facility on 2/21/24, readmitted on 1/8/25 with diagnoses that included dementia. A comprehensive Minimum Data Set (MDS) assessment was completed on 1/10/25 and indicated that Resident #63 was cognitively	F 656	Resident #63 careplan was revised to include a careplan for behavior management interventions, including the use of non-toxic markers on 2/26/2025 by Jennifer Clapp LPN Minimum Data Set Nurse (MDS). Resident #63 did not suffer any adverse effects related to alleged deficient practice. Resident #21 careplan was revised to include a careplan for anticoagulant and diuretic use on 2/26/2025 by Jennifer Clapp LPN Minimum Data Set Nurse (MDS) . Resident #21 did not suffer any adverse effects related to alleged deficient practice. Residents with potential to be affected The Director of Nursing (DON) completed a 100% audit on 3/4/2025 on all residents taking anticoagulant therapy and ensuring care plan was in place. On 3/10/2025 100 % audit completed for all residents on diuretic medication had care plan in place. On 3/18/2025 audit completed for all residents for a 7 day look back for any behaviors documented. Any resident with behavior management interventions had a careplan in place. 100% audit completed on residents with diagnosis of pain on 3/21/2025 to ensure pain care plan is in place. No other residents suffered any adverse effects related to the alleged deficient practice. Systemic changes Social worker and Minimum Data Set Nurse (MDS) #1 and Nurse #2 were educated by the Administrator on 3/24/2025 on the requirement that the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19 impaired, displayed no behaviors and had no upper extremity impairment. A review of the progress notes by Nurse #1 dated 1/30/25 revealed Resident #63 was observed sitting on the side of her bed with markers and appeared to have put green marker on her lips like lipstick. The active care plan was last reviewed and revised on 2/4/25. There were no revisions made that reflected the need for Resident #63 to have only non-toxic markers provided for her. A review of the progress notes by Nurse #2 dated 2/5/25 indicated Resident #63 was observed sucking on her markers and pointed to her lips and stated the word lipstick. An observation was made of Resident #63 on 2/26/25 at 8:38 AM. Resident #63 was seated in her wheelchair with bedside table in front of her and had non-toxic markers available in a container along with a coloring book. An interview was conducted with the Activities Director on 2/26/25 at 9:13 AM. She indicated that the family and the facility provided non-toxic markers to Resident #63 as coloring was important to her and staff were to redirect her as needed. An interview was conducted with the Unit Manager on 2/27/25 at 10:04 AM. She indicated Resident #63 had only non-toxic markers and per her family member's request, she was allowed to use non-toxic markers for an activity. She further revealed that staff have been told to redirect Resident #63 if she was seen sucking on	F 656	facility develop and implement a comprehensive and person-centered care plan that accurately reflects the needs of the resident. Any newly hired Social Worker or MDS Nurse are educated on this during orientation by another MDS Nurse or the Corporate Reimbursement Manager. Monitoring An audit tool will be used to observe for continued compliance with the plan of correction. The audit tool consists of the following: • Does the resident receive pain medication? Is there a care plan for pain in place? • Does the resident have behavior management interventions? Is there a care plan in place? • Does the resident receive anticoagulants and/or diuretics? Is there a care plan in place? DON or designee will complete audits on 10 residents per week times four weeks, then biweekly times four weeks, then monthly times one month. The results of these audits will determine the need for further monitoring. QAPI The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the DON for review and further recommendation. All corrective actions referenced in this Plan of Correction (POC) will be in place	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 20	F 656	by 3/24/2025	

markers or attempting to use the markers as lipstick.

An interview was conducted with the Medical Director on 2/27/25 at 11:59 AM. She indicated that she was aware and in support of Resident #63 having access to non-toxic markers for activity purposes but would be concerned for Resident #63's safety if she had access to non-toxic markers.

The MDS Nurse was interviewed on 2/27/25 at 10:21 AM and explained that the behavioral care plan should have been revised to indicate Resident #63 only needed to have access to non-toxic markers and to be redirected by staff if she was observed using markers as lipstick or sucking on the markers.

The Director of Nursing (DON) was interviewed on 2/27/25 at 5:25 PM and stated that Resident #63's change in behavior was discussed in staff morning meetings and that the MDS nurse should have updated her care plan to reflect the change in behavior.

3. Resident #21 was admitted to the facility on 1/22/25 with diagnoses that included atrial fibrillation and essential hypertension.

Physician orders dated 1/22/25 included Eliquis (an anticoagulant medication used to reduce the risk of forming blot clots) 5 milligrams (mg) twice a day and furosemide (a diuretic medication used to increase urine output by promoting the excretion of water and electrolytes from the kidneys) 20 mg once a day.

January 2025 and February 2025 Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 21 Administration Records (MAR) recorded Resident #21 received Eliquis 5mg twice a day and furosemide 20mg once a day from 1/22/25-2/27/25. The Admission Minimum Data Set (MDS) assessment dated 2/4/25 indicated Resident #21 was cognitively impaired, was coded for anticoagulant use. Resident #21's care plan reviewed dated 2/4/25 did not include a focus for the use of blood thinners and/ or anticoagulants or the use of diuretics. On 2/26/25 at 1:31 PM MDS Nurse #1 was interviewed. She verified the care plan for Resident #21 did not include a focus for the use of anticoagulants or the use of diuretics. She stated that it should have been added at the time the MDS was completed. The Director of Nursing (DON) was interviewed on 2/27/25 at 5:25 PM. She stated that a focus for anticoagulant and diuretic use should have been added to Resident #21's care plan.	F 656		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F 791		3/25/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 22 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident, staff, dentist, and physician interviews	F 791	Filing the plan of correction does not constitute that the alleged deficiencies did	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 23 the facility failed to obtain recommended dental services for 1 of 1 resident (Resident #32) reviewed for dental services. The findings included: Resident #32 was admitted to the facility on 3/5/24. Her diagnosis included exfoliation of teeth (process that allows the replacement of the primary dentition with permanent teeth) due to systemic causes, disorientation, hypertensive heart disease, chronic kidney disease, chronic diastolic (congestive) heart failure and periapical abscess without sinus (a dental abscess that occurs when bacteria infects the tooth's root and doesn't drain into a sinus). A quarterly MDS dated 11/24/24 revealed Resident #32 was cognitively intact. Resident #32 had no mouth pain, facial pain or difficulty chewing. She had no documented weight gain or weight loss. Her pain was documented at a 4 at its highest. Resident #32 was coded as receiving an opioid and she had scheduled and as needed (PRN) pain medication. A consultation/report letter dated 12/5/24 stated Resident #32 was seen in the dental office/oral surgeon for a consultation. Resident #32 was not a candidate for treatment to be done in the office setting. Resident #32 would need to be treated in a hospital setting. The recommendations stated that due to the health history of Resident #32 she was not a candidate for intravenous (IV) sedation in an outpatient setting. Resident #32 was referred back to the dentist to send to a hospital setting for the procedure to be completed. This note was signed by the Unit Manager who documented the	F 791	in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. F791 Resident Affected Resident # 32 had tooth extraction completed on 3/20/2025. She remains in the facility and has not suffered any sustained adverse effects related to the alleged deficient practice. All other residents with potential to be affected On 03/25/2025, the Social Worker interviewed residents with a BIMS score of 13 or above to ensure any dental requests had been addressed timely. There were no additional negative findings. On 03/25/2025, the Social Worker along with an additional staff member reviewed residents with a BIMS score of 12 or less to ensure any concerns voiced or documented in last 14 days related to dental issues had been addressed timely. No additional residents suffered any adverse effects related to the alleged deficient practice. Systemic change On 3/24/2025 the Administrator in-serviced the social worker and the Registered Nurse Supervisor (RN Supervisor) that the facility must provide/arrange for timely dental services	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 24 consultation report was faxed to the contracted mobile Dentist on 12/6/24. The facility's facsimile cover page dated 1/22/25 indicated a referral for Resident #32 to be seen by an outside dental agency. The facsimile documented: please call the Unit Manager to schedule an appointment or if you have any questions, and that resident required sedation. An interview with the Unit Manager on 2/27/25 at 11:28AM indicated consultation reports following an appointment would come to her either by fax or upon return from an appointment and she reviewed the consultations for further recommendations. She stated the oral surgeon recommendations dated 12/5/24 stated they could not perform the procedure (tooth extraction) on Resident #32 because they could not sedate her for the procedure. She stated following the recommendations from the oral surgeon on 12/5/24, she completed a referral for Resident #32 to be seen by a dental school on 1/22/25. The Unit Manager stated she was unsure of why she had not sent the referral to the dental school before 1/22/25. During the interview, the Unit Manager was observed to review her emails. She stated she had not received confirmation that Resident #32 could be seen by the dental school for the extraction. Additionally, during the interview, the Unit Manager was overheard calling the SW to determine if Resident #32 had been placed on the list for the contracted mobile dentist. It was confirmed that Resident #32 had not been seen by a dentist after the oral surgeon's appointment on 12/5/24. She revealed she had not followed up with the dental school to determine if the procedure could be completed per the referral she completed (1/22/25). The Unit	F 791	to residents, including when a resident requires dental services that must be performed in an acute setting. This in-service will be part of the orientation process for all newly hired social workers. Monitoring: The Administrator, Director of Nursing (DON), RN Supervisor and/or Licensed Practical Nurse (LPN) in charge will audit 5 residents weekly times four weeks, (on random halls to include all halls), then biweekly x 4 weeks, then monthly x 1 month to ensure any voiced or documented concerns related to dental status have been addressed timely. This audit will be documented on the dental audit tool. The results of these audits will determine the need for further monitoring. QAPI The results of these audits will be brought to the monthly Quality Assurance and Performance Improvement (QAPI) Committee for 3 months by the DON for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. Completion date March 25, 2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 25	F 791		

Manager indicated she should have followed up on the referral she sent to determine if Resident #32 could have an extraction at their office.

During an interview and observation of Resident #32 on 2/25/25 at 12:35pm the resident was observed eating her lunch. The meal was of regular texture. Resident #32 was observed to have eaten 75% of her meal. When asked how she was, Resident #2 stated she was "ok". Resident #32 did not exhibit any signs or symptoms of pain during the interview. Resident #32 indicated she had to have her tooth extracted because she had some tooth pain.

Observation and interview with Resident #32 on 2/27/25 revealed the resident was eating lunch. Her meal consisted of regular texture. Resident #32 did not exhibit any signs of symptoms of pain while chewing. Resident #32 was asked about her meal and did not indicate she was having any pain. Resident #32 stated she had not had her tooth extraction completed yet. She required a prompt to recall past dental visits.

The Social Worker (SW) was interviewed on 2/27/25 at 11:15AM. The SW stated she was responsible for completing referrals to include dental services. She had completed a referral for Resident #32 to see the contracted mobile Dentist on 10/7/24. The referral was made due to Resident #32 stating she needed a molar extraction. Any notes or recommendations from that appointment would have been reviewed and filed by the Unit Manager. The Unit Manager would then complete any after-visit notes. The SW stated she was not aware of the oral surgeon recommendations dated 12/5/24. She stated if the Unit Manager needed the SW to assist in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 26	F 791		

scheduling, she (the SW) would have tried to research a hospital that might be able to provide Resident #32 with any needed treatment. She stated Resident #32 had not been seen by a dentist for an oral exam since the consultation with the oral surgeon on 12/5/24.

In an interview with the contracted mobile Dentist on 2/27/25 at 2:15pm he revealed he completed his initial exam on Resident #32 on 10/22/24. He recalled Resident #32 having sensitivity of a crown on the lower left side of her mouth. With tapping and percussion Resident #32 had a little bit of pain. Resident #32 had said her previous exam (prior to admission to the facility) indicated she needed an extraction. The Dentist stated he did not take x-rays of tooth #19 (the tooth that required the extraction) to see exactly what the concern was, but he suspected possible nerve damage. He also assumed Resident #32's tooth sensitivity could have been from a possible abscess. Resident #32 was apprehensive of needles which was the reason he referred Resident #32 to have an extraction of tooth #19 with the oral surgeon. The oral surgeon could do deep sedation for dental procedures. He stated he could see a reply in the resident's electronic medical record from the oral surgeon on 12/5/24 with recommendations. The recommendations were to have the procedure done in a hospital setting, but there was no one in the area that he was aware of that would perform the type of procedure Resident #32 needed due to her medical condition and diagnosis.

In an interview with the Director of Nursing on 2/27/25 at 5:27PM she stated Resident #32 had a dental consultation report from the oral surgeon on 12/5/24 that stated she (the resident) could not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 27 be seen due to IV sedation and her diagnosis. A referral had been sent by the Unit Manager for Resident #32 to seen by a dentist at the dental school in January. The Unit Manager should have followed up on the referral for the dental school before today (2/27/25). In an interview with the Physician on 2/28/25 at 9:58AM she revealed the oral surgeon felt Resident #32 needed general anesthesia to have her tooth extracted. It could be difficult to locate a dentist to do general anesthesia on Resident #32 due to her health condition from a cardiology standpoint. If the facility was unable to find an inpatient factility to do the dental procedure under general anesthesia, the facility should have made her aware so she could attempt to locate an alternative. She was unsure if Resident #32 had a dental visit by the contracted mobile Dentist following the 12/5/24 appointment with the oral surgeon. She would have expected a referral be sent out for Resident #32 to be seen for oral care before 3 or 4 weeks ago (1/22/25) but due to holidays in-between that time it could have caused delay. She further stated Resident #32 was clinically stable and had no complaints regarding tooth pain prior to her appointment with the oral surgeon or thereafter. The facility needed to figure out how to take care of the resident's extraction but not in an emergency setting. The Physician stated she would need to talk with the Nurse and SW to identify a plan.	F 791		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		3/27/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 28	F 880		

designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 29 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to implement infection control policies and procedures when Nurse Aide #1 and Housekeeper #1 failed to don all the required Personal Protective Equipment (PPE) before entering a room with a resident on special contact-droplet precautions. This occurred for 2 of 2 staff observed for infection control practices (Nurse Aide #1 and Housekeeper #1). The findings included: The facility's Infection Prevention and Control Program policy last revised on 12/23/24 and read	F 880	F880 The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities' desire to comply with the regulation and to provide high quality care. Residents affected: Resident #127 did not suffer any adverse effects related to the alleged deficient practice. Resident #127 has since been discharged from facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 in part:" The infection Prevent and Control Program of this facility maintains an organized, effective, facility wide program designed to systematically identify and reduce the risk of acquiring and transmitting infections among residents, visitors, and employees. This program involves the collaboration of many programs and services within the facility and is designed to meet the intent of regulatory and accrediting agencies. Review of the facility's special contact droplet precautions last revised 12/23/24 read in part, "personal protective equipment: put on in this order alcohol-based hand rub or wash with soap and water if visibly soiled, gown, fit tested NIOSH approved respirator (N95) or higher-level respirator, put on eye protection (face shield or goggles), and gloves. 1. An observation was conducted on 02/24/25 at 12:03 PM of Nursing Assistant #1 (NA#1). NA #1 entered room 612 to deliver Resident #127's lunch meal tray wearing only a surgical mask. The signage that was on the wall beside the room door read in part, "special droplet contact precautions." An interview was conducted with NA #1 on 02/24/25 at 12:05 PM and she stated, "it's confusing, I thought as long as I was not providing patient care it was ok, since I was just taking the tray in the room." An interview was conducted on 02/24/25 at 12:11 PM with Nurse #3. Nurse #3 stated Resident #127 was on isolation precautions for Respiratory syncytial virus (RSV) and Influenza. She indicated staff were supposed to put on the PPE prior to entering the room.	F 880	On 2/25/2025 education was provided for Nurse Aide #1 and Housekeeper #1 regarding Transmission-based precautions and the requirement that all employees, including contracted employees, must follow transmission-based precautions and don/doff personal protective equipment (PPE) according to the instructions on the sign that is posted to the resident's door. The Registered Nurse (RN) Supervisor completed this education. All other residents with potential to be affected: All residents requiring Transmission-based precautions were observed by the RN Supervisor on 2/25/2025, 2/26/2025, and 2/27/2025 to ensure that all employees were following the PPE requirements that were posted on the sign on the residents' doors. There were no other incidents of employees not donning/doffing all the PPE that was required. No other residents suffered any adverse effects related to the alleged deficient practice. Systemic changes All facility staff, including contracted staff, will be educated on Transmission-based precautions and the requirement for all staff to don/doff all the PPE required based on the sign that is posted on the residents' door. This education was initiated by the RN Supervisor on 2/25/2025 and will be completed by the RN Supervisor, Director of Nursing (DON) and/or Licensed Practical Nurse (LPN)'s	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 02/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31 2. On 02/25/25 at 09:21 AM and observation was conducted of Housekeeper #1 in room 612 mopping the floor with a surgical mask and gloves on. The signage that was on the wall beside the room door read in part, "special droplet contact precautions." During the observation the Unit Manager went to the door of the room #612 and instructed Houskeeper #1 to come out of the room and she informed him that he was supposed to have on a N95, gown and face shield as well. An interview was conducted on 02/25/25 at 9:24 AM with Housekeeper #1. He indicated he was not aware that he was supposed to put the PPE on that was listed on the special droplet precautions sign. During an interview with the Director of Nursing on 02/25/25 at 9:32 AM she stated, "They're not reading the signs." The DON further stated, "we haven't had an isolation in a while." The DON indicated she expected staff to read the signage and put on the PPE that was listed on the signage. An interview was conducted with the Administrator on 02/27/25 at 5:45 PM. He indicated staff should read the signs to understand the precautions before entering a room.	F 880	in charge by 3/27/2025. Any staff out on leave or PRN status will be educated by the RN Supervisor and/or DON prior to returning to their assignment. Any newly hired staff will be educated by the DON/RN Supervisor/Staff Development Coordinator (SDC) or LPN in Charge during orientation. Monitoring: An audit tool will be used to observe for continued compliance with the plan of correction. The audit tool consists of the following: • Staff following transmission-based precautions and donning/doffing all PPE as posted on the resident's door. The DON, SDC, RN Supervisor or LPN in charge will observe three employees weekly to include each shift and weekends for one month, then three employees bi-weekly for one month and then five employees monthly for one month. The results of these audits will determine the need for further monitoring. QAPI The DON will bring the results of the audits to the Quality Assurance and Performance Improvement (QAPI) Committee monthly times three months for review and further recommendations to ensure compliance with this plan of correction. Date of completion: March 27, 2025	