DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/08/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING ______ B. WING ______	C 01/25/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	700 SELF ST CHERRYVILLE, NC 28021

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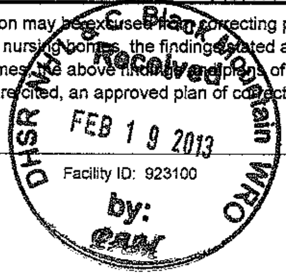
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation. Event ID #OLKS11.	F 000	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews, and record review, the facility failed to develop a care plan to prevent further decrease in range of motion and splint application for 2 of 3 sampled residents with contractures (Residents #2 and #3). The findings are:	F 279	F279 For Residents #2 and #3, the care plans were updated to reflect range of motion exercises and splint application as appropriate per resident re-evaluation by Occupational Therapy. For all residents with the potential to be affected, 100% of the residents' medical records were audited based on therapy restorative nursing referrals to verify the care plans included splint application and preventing further decrease in range of motion and care plans were updated as needed. One to one education was completed with the MDS Coordinator by the Director of Nursing regarding care plans to include preventing further decrease in range of motion and splint application.	2/1/13 2/15/13 2/15/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Mitchell — TITLE: Administrator — (X6) DATE: 2/15/13

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.



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F 279	Continued From page 1 1. Resident #3 was readmitted to the facility on 6/29/11 with diagnoses which included Cerebral Vascular Disease. Review of Resident #3's occupational therapy plan of care and service dated 09/2712 to 10/27/12 revealed Resident #3 received right hand splinting and passive range of motion to the right upper extremity. Review of Resident #3's care plan dated 01/01/13 revealed there was no direction for splint application or interventions to prevent a further decrease in range of motion. Review of the quarterly Minimum Data Set (MDS) dated 01/02/13 revealed Resident #3's cognition as intact with functional impairment of range of motion on one side of the upper extremity. Interview with Resident #3 on 01/23/13 at 8:40 AM revealed nursing staff exercised his hands during daily care. Resident #3 reported he used to wear the splint in his room but could not apply it independently. Observations on 01/23/13 at 10:30 AM and at 2:30 PM revealed Resident #3 did not wear a hand splint on the contracted right hand. Further observations on 01/24/13 at 8:00 AM and at 10:10 AM revealed Resident #3 did not wear a hand splint on the contracted right hand. Interview with Nurse Aide (NA) #1 on 01/24/13 at 10:32 AM revealed she did not apply Resident #3's hand splint. NA #1 explained she did not apply or offer the hand splint because she	F 279	Audits of 100% of all residents' future care plans will be completed quarterly with the MDS schedule for the next six months by the RN or Director of Nursing. Continued audits will be dependent upon the results of prior audits. All audit information will be analyzed and discussed by the Director of Nursing at the QA Committee meetings.	2/15/13

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F 279	Continued From page 2 thought Resident #3 no longer used it. NA #1 explained she thought Resident # 3 refused the splint application in the past. Interview with the Occupation Therapy Assistant (OTA) on 01/24/13 at 12:08 PM revealed Resident #3's right hand splint should be worn 6 to 8 hours as tolerated. The OTA explained she informed nursing staff of this requirement orally and in writing. Interview with Nurse #2 on 01/24/13 at 12:24 PM revealed there was no documentation or direction for Resident #3's right hand splint application. Nurse #2 explained nursing staff did not apply the hand splint. Interview with the MDS Nurse on 01/24/13 at 3:02 PM revealed she was responsible for Resident #3's care plan. The MDS Nurse reported the splint application and range of motion exercises should be on the care plan. Interview with the Director of Nursing on 01/24/13 at 3:35 PM revealed she expected Resident #3's care plan to include the interventions of splint application and range of motion exercises. 2. Resident #2 was admitted on 10/04/11 with diagnoses which included quadriplegia. Review of Resident #2's quarterly Minimum Data Set (MDS) dated 1/10/13 revealed intact cognition and impaired functional range of motion of all extremities. Review of Resident #3's care plan dated 01/10/13 revealed there was no indication of contractures	F 279		

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F 279	Continued From page 3 or interventions to prevent further decrease in range of motion. Observation of Resident #2 on 01/23/13 at 10:18 AM revealed both hands contracted. Interview with Resident #2 on 01/24/13 at 10:11 AM revealed nursing staff exercised both hands daily. Interview with the MDS Nurse on 01/24/13 at 3:15 PM revealed she was responsible for Resident #2's care plan. The MDS Nurse reported Resident #2's contractures and range of motion exercises should be included on the care plan. Interview with the Director of Nursing on 01/24/13 at 3:35 PM revealed she expected Resident #2's care plan to address the contractures and include the range of motion exercises.	F 279		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, and record review, the facility failed to apply a hand splint for 1 of 3 sampled residents with contractures (Resident #3).	F 318	F 318 For Resident #3, a referral was made to Occupational Therapy for a splint application restorative nursing program. For all residents with the potential to be affected, an audit was completed to verify that restorative nursing programs were in place for splint application to prevent further decrease in range of motion. Referrals were made to Occupational Therapy as needed for evaluation and implementation of a splint application program.	2/1/13 1/25/13

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F 318	Continued From page 4 The findings are: Resident #3 was readmitted to the facility on admitted on 6/29/11 with diagnoses which included Cerebral Vascular Disease. Review of Resident #3's occupational therapy plan of care and service dated 09/2712 to 10/27/12 revealed Resident #3 received right hand splinting. Review of Resident #3's care plan dated 01/01/13 and the undated resident care information sheet revealed there was no direction for splint application. Review of the quarterly Minimum Data Set (MDS) dated 01/02/13 revealed Resident #3's cognition as intact with functional impairment of range of motion on one side of the upper extremity. Observations on 01/22/13 at 10:35 AM and on 01/23/13 at 8:35 AM revealed Resident #3 did not wear a hand splint on the contracted right hand. Interview with Resident #3 on 01/23/13 at 8:40 AM at revealed nursing staff exercised his hands during daily care. Resident #3 reported he used to wear the splint in his room but could not apply it independently. Observations on 01/23/13 at 10:30 AM and at 2:30 PM revealed Resident #3 did not wear a hand splint on the contracted right hand. Observations on 01/24/13 at 8:00 AM and at 10:10 AM revealed Resident #3 did not wear a	F 318	Education was provided to all therapists by the Therapy Program Manager regarding communication with the MDS Coordinator of all restorative nursing programs. Education was provided to all nursing staff by the MDS Coordinator regarding referring to the resident care information sheet to ascertain any device usage. A Restorative Nursing Log was established to improve communication between therapy and nursing and is reviewed and signed by the Therapy Manager and MDS Coordinator each time a new restorative program is implemented. The RN/ Director of Nursing will review the log weekly for eight weeks. Continued audits will be dependent upon the results of prior audits. All audit information will be analyzed and discussed by the Director of Nursing at the QA Committee meetings.	1/29/13 1/29/13 1/29/13

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F 318	Continued From page 5	F 318		

hand splint on the contracted right hand.

Interview with Nurse Aide (NA) #1 on 01/24/13 at 10:32 AM revealed she did not apply Resident #3's hand splint. NA #1 explained she did not apply or offer the hand splint because she thought Resident #3 no longer used it. NA #1 explained she thought Resident # 3 refused the splint application in the past.

Interview with Nurse #1, the charge nurse, on 01/24/13 at 11:03 AM revealed each nurse aide is responsible for splint application. Nurse #1 reported she was not certain if Resident #3 required a hand splint.

Observation on 01/24/13 at 11:36 AM revealed Resident #3 with a right hand splint and NA #1 reported she applied the splint without difficulty.

Interview with the Occupation Therapy Assistant (OTA) on 01/24/13 at 12:08 PM revealed Resident #3 should wear the right hand splint 6 to 8 hours daily or as tolerated. The OTA explained she informed nursing staff of this requirement orally and in writing.

Interview with Nurse #2 on 01/24/13 at 12:24 PM revealed there was no documentation or direction for Resident #3's right hand splint application. Nurse #2 explained nursing staff did not apply the hand splint.

Interview with the MDS Nurse on 01/24/13 at 3:02 PM revealed she was responsible for restorative nursing care which included splint application. The MDS Nurse reported she was not aware Resident #3 required a splint application.

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F 318	Continued From page 6 Interview with the Director of Nursing on 01/24/13 at 3:35 PM revealed she expected Resident #3 to have the splint applied and documented on the restorative nursing care plan.	F 318		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review the facility failed to serve a physician ordered mechanical soft diet for one (1) of four (4) sampled residents with a therapeutic diet ordered. (Resident #6) The findings are: Resident #6 was admitted to the facility on 8/9/12 with diagnoses which included chronic obstructive pulmonary disease and atrial fibrillation. Review of Minimum Data Set (MDS) dated 11/3/12 assessed Resident #6 as cognitively intact, able to eat independently with tray set up only. The MDS indicated Resident #6 was on a mechanically altered therapeutic diet. Review of physician order dated 9/12/12 revealed orders for mechanically soft no added salt (NAS) diet. Record review revealed Resident #6 was seen by speech therapy for diagnosis of dysphagia.	F 367	F367 For Resident #6, the tray card was changed to boldly highlight the mechanical soft diet and the resident is served the appropriate physician ordered diet. For all residents, 100% of all residents' tray cards were reviewed to match the physician diet orders and the tray cards were changed to boldly highlight the diets. Education was provided to all dietary staff by the Registered Dietitian regarding therapeutic diets and tray accuracy. Education was provided to all nursing staff by the Staff Development Coordinator regarding therapeutic diets and checking each tray for accuracy prior to serving. A tray line accuracy checklist was developed to be utilized at each meal by the dietary supervisor to ensure trays are correct.	1/24/13 1/24/13 1/24/13 1/24/13

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F 367	Continued From page 7 Review of therapy progress notes dated 8/24/12 to 9/10/12 indicated Resident #6 required a mechanical soft diet. Resident #6 was discharged from speech therapy on 9/10/12 with no further diet upgrade indicated. Observation on 1/24/13 at 12:45 PM revealed Resident #6 seated in her room eating her lunch meal which included a slice of baked ham. The meat was cut into approximately six to eight pieces. The dietary slip on the lunch tray listed a mechanical soft nas diet with ground baked ham. Resident #6 was observed eating her meal with no difficulty chewing or swallowing. Interview with the Dietary Manager and the Registered Dietitian on 1/24/13 at 2:40 PM confirmed that Resident #6 was not served ground baked ham for lunch as listed on the dietary therapeutic spreadsheet. Interview with the Speech Therapist on 1/24/13 at 5:45 PM stated that Resident #6's mechanical soft diet required meats to be ground as ordered and that it would not be appropriate to provide meats cut up for the resident.	F 367	The District Manager will be utilizing the tray assessment worksheet weekly to monitor therapeutic accuracy. Audits of 10% of all residents' tray card accuracy will be completed weekly for eight weeks. Continued audits will be dependent upon the results of prior audits. All audit information will be analyzed and discussed by the Dietary Manager at the QA Committee meetings.	2/5/13