| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345494 | A. BUILDING _____ B. WING _____ | C 05/06/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| PEAK RESOURCES - GASTONIA | 2780 X-RAY DRIVE GASTONIA, NC 28054 |

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| F 000 | INITIAL COMMENTS<br><br>No deficiencies were cited as a result of the complaint investigation. Event ID #GHLT11. | F 000 | | |
| F 166 SS=D | 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES<br><br>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews the facility failed to conduct a thorough investigation of a grievance for 1 of 1 resident reviewed for grievances (Resident #86).<br><br>The findings included:<br><br>Resident #86 was admitted to the facility on 10/11/12 with diagnoses of diabetes and seizure disorder. The quarterly Minimum Data Set (MDS) dated 01/15/15 revealed Resident #86 was cognitively intact.<br><br>Review of the facility Grievance Reporting Form dated 06/10/14 revealed Resident #86 stated she was missing two 14 carat gold necklaces with crosses. The grievance form revealed the 2 necklaces had been missing for 2 to 3 weeks. The grievance further revealed the high school students in the Health Occupation Class had gone through Resident #86's bedside table drawers to see if she had medications in her room in 05/2014. The investigation/action/solution revealed the Social Worker (SW) spoke with the | F 166 | Affected Resident:<br><br>Resident #86 discharged from facility on 3/3/2015.<br><br>Potentially Affected Resident:<br><br>Any resident who has expressed concern on a concern/grievance form has the potential to be affected.<br><br>Administrator reviewed last 30 days of Concern/Grievance logs to identify any areas where a more thorough investigation may be needed. Tool utilized with the following questions: Was Concern/Grievance form completed in its entirety ; were resident issues addressed in a timely manner (within policy requirements) ; was resident/resident representative satisfied with resolution? - if no, was appropriate follow up completed? | 6/3/15 |

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

Electronically Signed | 05/30/2015

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 166 | Continued From page 1<br>nurse aide (NA) regarding the missing necklaces and the high school students going through Resident #86's drawers. The NA reported the high school students completed an inventory sheet of Resident #86's belongings but she did not recall Resident #86 having 2 gold necklaces with crosses. The SW informed Resident #86 the items had not been found and she needed to report missing items as soon as possible. The grievance further revealed Resident #86 did not have an inventory sheet and therefore per the Administrator the necklaces would not be replaced.<br><br>During an interview conducted on 05/05/15 at 3:43 PM the SW confirmed she investigated the grievance Resident #86 filed about the 2 missing 14 carat gold necklaces with crosses on 06/10/14. The SW reported the necklaces had been missing 2 to 3 weeks and Resident #86 told her the high school students had gone through her bedside table drawers during that time. She stated she interviewed the NA that worked with Resident #86 and she confirmed the high school students had gone through her drawers because they were doing an inventory sheet. The SW stated the NA did not recall Resident #86 having 2 gold necklaces with crosses on them. The SW stated she could not find an inventory sheet for Resident #86 in her chart and assumed she didn't have one. She stated every resident should have an inventory sheet and the resident, family or SW should complete the inventory sheet. The SW stated she reported the missing necklaces to the Administrator and because Resident #86 didn't have an inventory sheet the items were not replaced.<br><br>An interview was conducted with the | F 166 | All concern/grievances addressed appropriately.<br><br>Inventory sheets updated for all current residents.<br><br>Measures/Systemic Changes:<br><br>Social Work Department in-serviced on proper investigation regarding Concern/Grievances to include: thorough investigation of items reported missing.<br><br>Inventory documentation will be completed upon admission for all new residents. Nursing staff will be responsible for editing/updating inventory sheets. All staff educated on process.<br><br>Monitoring:<br><br>A monitoring tool was developed to monitor thorough investigations being conducted on concern/grievances to include, but not limited to: Was Concern/Grievance form completed in its entirety ; were resident issues addressed in a timely manner (within policy requirements) ; was resident/resident representative satisfied with resolution? - if no, was appropriate follow up completed?<br><br>Administrator (or DON) to conduct weekly audits of inventory sheet completion of 10% of residents for 4 weeks, then 10% of residents every 2 weeks for 4 weeks, then 10% of residents monthly for 2 | |

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| F 166 | Continued From page 2<br>Administrator on 05/05/15 at 4:56 PM. The Administrator stated she reviewed the grievance filed by Resident #86 on 07/01/15 which stated she was missing two 14 carat gold necklaces with crosses on them. The Administrator stated she was not aware the high school students had gone through Resident #86's drawers or had completed inventory sheets. She stated when she received the grievance the students had finished their rotation and were no longer in the building. The Administrator indicated she did not call the instructor to ask about the inventory sheet or missing necklaces. The Administrator further stated she did not interview the NA's or any staff about the missing necklaces. The interview further revealed the necklaces were not replaced because Resident #86 did not have an inventory sheet and if there had been an inventory sheet and the necklaces were listed they would have been replaced.<br><br>During a follow up interview on 05/06/15 at 10:50 AM the Administrator revealed she had interviewed the NA and the Nurse that worked with Resident #86 on 05/06/15. She stated the NA reported the high school students completed the inventory sheet for Resident #86 and she gave the completed inventory sheet to the nurse on duty. The Administrator stated the nurse that was on duty reported he transcribed the inventory sheet to the computer. The Administrator stated she went into the computer this morning and found the inventory sheet from 05/2014 and a yellow necklace was listed. The Administrator stated she should have conducted a more thorough investigation of the grievance. | F 166 | months. Continued audits will be determined based on results of prior 4 months audits.<br><br>A monitoring tool was developed to monitor completion of inventory sheets for all residents upon admission.<br>SW (or Administrator) to conduct weekly audits of inventory sheet completion of 10% of residents for 4 weeks, then 10% of residents every 2 weeks for 4 weeks, then 10% of residents monthly for 2 months. Continued audits will be determined based on results of prior 4 months audits.<br><br>All audit results reviewed during monthly QAPI meeting for a minimum of 4 months. | |
| F 246 SS=D | 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES | F 246 | | 6/2/15 |

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| F 246 | Continued From page 3<br><br>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review the facility failed to follow-up with a resident's request for assist rails for 1 of 1 resident that requested assist rails (Resident #107).<br><br>The findings included:<br><br>Resident #107 was admitted to the facility on 03/03/15 with diagnoses that included weakness, obesity, heart failure and others. The most recent Minimum Data Set (MDS) dated 03/17/15 specified the resident's cognition was intact and the resident required extensive assistance with bed mobility was frequently incontinent of bowel and bladder and did not use side rails.<br><br>Resident #107's care plan updated on 03/20/15 for activities of daily living (ADL) revealed the resident required assistance with ADL due to obesity. Interventions identified in the care plan included turn and reposition during rounds and staff to assist resident with ADL allowing resident to perform as much as possible for each task.<br><br>On 05/04/15 at 4:00 PM Resident #107 and a family member were interviewed together. | F 246 | Affected Resident:<br><br>Resident #107 was provided with assist rails.<br><br>Potentially Affected Resident:<br><br>100% of resident/resident representatives interviewed to identify residents who prefer/need assist rails.<br><br>All residents who need assist rails have them in place.<br><br>Additional assist rails have been ordered and will be provided to any resident with a preference for assist rails upon receipt of order.<br><br>Measures/Systemic Changes:<br><br>All staff in-serviced on: identifying residents who need assist rails; accommodating residents who prefer assist rails; procedure for completing a request for assist rails (review of therapy referral and review of Maintenance | |

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| F 246 | Continued From page 4<br>Resident #107 was in bed and reported that she had made several requests to nursing staff for "side rails" on her bed to assist her with turning in the bed. Resident #107 added that "side rails" would enable her to sit up in bed independently. Resident #107 stated that it was difficult for her to turn in bed and demonstrated how she had to grab the edge of the mattress to roll over in bed. Resident #107 stated that she was told the facility did not allow "side rails." Resident #107 reported that she could not recall the names of staff who had told her she could not have "side rails."<br><br>On 05/05/15 at 10:24 AM incontinence care was observed with Resident #107's permission. Nurse aide (NA) #2 provided the incontinence care. Observations of the incontinence care revealed that when Resident #107 was instructed to turn to the right, she had to hold on to her locked wheelchair next to the bed for support. When Resident #107 was instructed to turn to the left, the Resident held onto the drawer pulled out of her nightstand for support. Resident #107 stated that she would like to have "side rails" because she had a difficult time supporting her weight and turning side to side during incontinence care. Resident #107 stated she had asked several staff for side rails. NA #2 reported that she also had requested side rails for the resident. 05/05/15 10:24 AM Observed NA perform incontinence care for Resident #107, no breaks in infection control, good technique, wiped front to back. Resident told surveyor she would like to have side rails to hold on to and has told staff she would like to have them. NA stated she had also told the nurse Resident wanted side rails. During care observed resident to hold on to her locked wheelchair when turned to her right side and she held on to the open bedside table | F 246 | Request.<br><br>All staff in-serviced on side rails vs. assist rails.<br><br>Assist rail need/preference to be reviewed upon admission and as needed per resident request.<br><br>Monitoring:<br><br>A monitoring tool was developed to monitor accomodation of need/preference for assist rails. Monitor tool included: Are rails in place for those residents evaluated/assessed for need of assist rails? ; If resident does not need assist rails - Do you prefer to have assist rails on your bed? ; If you have needs/preferences that need to be addressed, do you know who to talk to?<br><br>DON (or Administrative Nurse) to conduct weekly audits of 10% of residents for 4 weeks, then 10% of residents every 2 weeks for 4 weeks, then 10% of residents monthly for 2 months. Continued audits will be determined based on results of prior 4 months of audits.<br><br>Audit results will be reviewed during monthly QAPI meeting for a minimum of 4 months. | |

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| F 246 | Continued From page 5 | F 246 | | |

drawer when turned to her left side for support.

On 05/05/15 at 10:30 AM the Director of Nursing (DON) was interviewed and reported that the facility did not use side rails but had smaller "assist rails" that attached to the tops of beds that provided support to residents with turning and repositioning. She explained that the facility's beds were older and not equipped with "assist rails" (side rails attached to the top half of the bed to provide assistance for residents to turn and reposition in bed). The DON added that residents were assessed on admission for the need for "assist rails" by the therapy department. The DON added that at anytime a resident or nursing staff felt assist rails were needed then a referral was made to therapy for an evaluation. The DON reported that assist rails would be appropriate for obese residents or residents that had difficulty turning in bed. The DON stated that she was unaware of Resident #107's request for side/assist rails.

On 05/05/15 at 10:35 AM Nurse #1 was interviewed and reported that the facility did not allow side rails. She added that if "assist rails" were different than "side rails." She explained that if she felt a resident would benefit from "assist rails" then she would make a referral to therapy. The nurse stated that she was unaware of Resident #107's request for rails on her bed. Nurse #1 added that she did not think Resident #107 needed assist rails because she thought the resident could turn independently in bed.

On 05/05/15 at 10:50 AM the physical therapist was interviewed and reported that Resident #107 was assessed on admission for assist rails. He reported that the resident on 03/04/15

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| F 246 | Continued From page 6<br>demonstrated that she was able to move independently in bed and rails were not needed. He added that if at any time staff or the resident felt rails were needed then a referral should be made. He stated that no referrals for Resident #107 regarding the use of rails had been made.<br><br>On 05/05/15 at 12:10 PM NA #2 was interviewed and reported that Resident #107 had difficulty maintaining a side position during incontinence care. She added that Resident #107 repeatedly asked for rails on her bed so that she could hold on to support herself. NA #2 stated that she told Nurse #1 of the resident's request.<br><br>On 05/06/15 at 9:30 AM the DON was interviewed again and reported that she would have expected Nurse #1 to follow-up with Resident #107's request for rails. | F 246 | | |
| F 272 SS=D | 483.20(b)(1) COMPREHENSIVE ASSESSMENTS<br><br>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.<br><br>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:<br>Identification and demographic information;<br>Customary routine;<br>Cognitive patterns;<br>Communication;<br>Vision;<br>Mood and behavior patterns; | F 272 | | 6/1/15 |

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| F 272 | Continued From page 7<br>Psychosocial well-being;<br>Physical functioning and structural problems;<br>Continence;<br>Disease diagnosis and health conditions;<br>Dental and nutritional status;<br>Skin conditions;<br>Activity pursuit;<br>Medications;<br>Special treatments and procedures;<br>Discharge potential;<br>Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and<br>Documentation of participation in assessment.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility failed to complete Care Area Assessments that addressed the underlying causes, contributing factors, and risk factors for 9 of 24 sampled residents reviewed for the most recent comprehensive Minimum Data Set (Residents #132, #50, #11, #27, #214, #26, #67, #19, and #129).<br><br>The findings included:<br><br>1. Resident #132 was admitted on 10/11/11 with diagnoses including dementia with behavioral disturbance. Review of the most recent comprehensive Minimum Data Set (MDS) dated | F 272 | Affected Resident:<br><br>CAAs for the following residents (#132, #50, #11, #27, #67, #19, #129) reviewed. Updates made to address underlying causes, contributing factors and risk factors of any triggered area.<br><br>Resident #214 discharged from facility on 7/29/2014.<br><br>Resident #26 discharged from facility on 3/29/2015.<br><br>Potentially Affected Resident: | |

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| F 272 | Continued From page 8<br>10/07/14 revealed Resident #132 refused to answer the questions for the brief interview for mental status, had no memory problems, and moderately impaired cognitive skills for daily decision making. The MDS dated 10/07/14 also noted sleep problems, feeling tired or having little energy, and rejection of care. Care Area Assessments (CAA) triggered from the most recent comprehensive MDS included: Cognitive Loss/Dementia, Mood State, and Behavioral Symptoms.<br><br>Review of the CAA Summary for Cognitive Loss/Dementia dated 10/07/14 stated Resident #132 triggered due to the diagnosis of dementia and she would need to assistance to be reoriented and needed assistance with making reasonable life decisions. The CAA summary for Mood State included the checked times but no supporting documentation. The CAA summary for Behavioral Symptoms stated Resident #132 triggered due to noncompliance with lab draws and skin audits. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for any of these CAA Summaries.<br><br>During an interview on 05/06/15 at 2:39 PM the Social Worker (SW) confirmed she had completed Resident #132's CAA Summaries for Cognitive Loss/Dementia, Mood State, and Behavioral Symptoms for the comprehensive MDS completed on 10/07/14. The SW stated she received MDS training from her supervisor when she was hired approximately 15 years ago. The SW further stated she did not include a narrative in the analysis of findings which documented the description of the problem, causes and contributing factors, and related risk factors | F 272 | All residents identified to have the potential to be affected.<br><br>Measures/Systemic Changes:<br>Regional Care Manager in-serviced Interdisciplinary Team Members responsible for completing CAAs on addressing underlying causes, contributing factors and risk factors of triggered areas.<br><br>Monitoring:<br><br>A monitoring tool was developed to monitor CAAs addressing: underlying causes of triggered areas ; contributing factors of triggered areas ; risk factors of triggered ; and was there supporting documentation for triggered areas?<br><br>Administrator (or Administrative Nurse) to conduct weekly audits of 2 residents weekly for 4 weeks, then 3 residents every 2 weeks for 4 weeks, then 4 residents monthly for 2 months. Continued audits will be determined based on results of prior 4 months of audits.<br><br>Audit results will be reviewed monthly during QAPI meeting for a minimum of 4 months. | |

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| F 272 | Continued From page 9 | F 272 | | |

because she did not know it was required.

2. Resident #50 was admitted on 05/10/13 with diagnoses including dementia, depression, and anxiety disorder. Review of the most recent comprehensive Minimum Data Set (MDS) dated 04/02/15 revealed Resident #50 had severe cognitive impairment and had received antidepressant and antipsychotic medications daily during 7 day assessment period. The MDS dated 04/02/15 also noted diagnoses including dementia, anxiety disorder, schizophrenia, and depression.

Review of the Care Area Assessment (CAA) Summary for Mood State dated 04/02/15 revealed it triggered due to Resident #50's mood score being greater than the previous assessment. One of the checked items indicated a clinical or functional change and the supporting documentation stated Resident #50 was holding food in her mouth and a referral had been made to speech therapy. The analysis of findings stated Resident #50 triggered due to the mood interview. There was no description of the problem, causes and contributing factors, or related risk factors included in the analysis of findings for the Mood State CAA Summary.

During an interview on 05/06/15 at 2:39 PM the Social Worker (SW) confirmed she had completed Resident #50's Mood State CAA Summary for the comprehensive MDS completed on 04/02/15. The SW stated she received MDS training from her supervisor when she was hired approximately 15 years ago. The SW further stated she did not include a narrative in the analysis of findings which documented the description of the problem, causes and

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contributing factors, and related risk factors because she did not know it was required.

3. Resident #11 was admitted to the facility on 12/28/14 with diagnoses of diabetes, hypertension and non-Alzheimer's dementia. The annual Minimum Data Set (MDS) dated 04/02/15 revealed Resident #11 was cognitively intact and required extensive assistance with transfers and toileting.

Review of the Care Area Assessment (CAA) dated 04/02/15 revealed a checklist but no analysis of how the checked items affected Resident #11 or what direction the care plan would take. Example as follows:

Falls was a checklist with the only additional information being the resident triggered due to impaired balance and daily use of psychotropic medications for treatment of depression. Resident #11's quarterly fall risk score was = 7, or high risk. Resident had no falls in last 3 months. Resident reported a history of arthritis in her knees that made it difficult to maintain standing for more than a few minutes at a time. This was written by the MDS Coordinator.

An interview was conducted on 05/06/15 at 2:21 PM with the MDS Coordinator. She stated the CAA summary or analysis of findings should show the strength and weaknesses of the resident and paint a picture of the resident and what direction the care plan should take. She stated the analysis of findings for Resident #11 did not paint a picture of the resident.

4. Resident #27 was admitted to the facility on 05/11/12 with diagnoses of hypertension and

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Alzheimer's disease. The quarterly Minimum Data Set dated 04/02/15 revealed Resident #27 was severely cognitively impaired. The MDS further revealed Resident #27 required extensive assistance with transfers, bed mobility and toileting.

Review of the Care Area Assessment (CAA) dated 03/11/15 revealed a checklist but no analysis of how the checked items affected Resident #27 or what direction the care plan would take. Example as follows:

Falls was a checklist with the only additional information being the resident triggered due to balance. Her quarterly screen fall risk score was = 20, or high risk. She had not had any falls in the last 3 months. This was written by the MDS Coordinator.

An interview was conducted on 05/06/15 at 2:21 PM with the MDS Coordinator. She stated the CAA analysis of findings should show the strength and weaknesses of the resident and paint a picture of the resident and what direction the care plan should take. She stated the analysis of findings for Resident #27 did not paint a picture of the resident.

5. Resident #214 was admitted to the facility on 07/13/14. Resident #214's diagnoses included respiratory failure, late effect-intracranial injury and muscle weakness.

The Admission Comprehensive Minimum Data Set (MDS) assessment dated 07/20/15 indicated that Resident #214 was cognitively intact, and required extensive assistance with personal hygiene, toileting, dressing, transfers and bed

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mobility.

Review of the CAA dated 07/20/14 focused on Resident #214's use of psychotropic drugs recorded that Resident #214 was taking antidepressant medication but was not taking antianxiety medication.

Resident #214's psychotropic drug use CAA dated 07/20/14 informed by a check block response only that Resident #214 was not experiencing any adverse consequences of psychotropic medication requiring an unnecessary drug evaluation. This data was then contradicted by a check block response only that Resident #214 was exhibiting anxiety and an increased risk for falls as an adverse consequence of the use of antidepressant psychotropic medication.

No supporting documentation was provided in Resident #214's CAA dated 07/20/14 that Resident #214 was exhibiting anxiety or an increased risk for falls related to her use of antidepressant medications.

The CAA's analysis of findings assessment dated 07/20/14 concerning psychotropic drug use informed only that Resident #214 was prescribed psychotropic medication for the treatment of insomnia specifying that she receives Remeron 15mg at bedtime and is prescribed Diazepam, which is classified as an antianxiety psychotropic medication, 2.5mg as needed daily for anxiety noting that Resident #214 did not receive any Diazepam during that assessment period and did not have any adverse effects related to Remeron.

The CAA's analysis of findings assessment dated

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07/20/14 concerning psychotropic drug use did not provide any information related to signs and symptoms of anxiety which was indicated as an adverse consequence of the use of antidepressant medication or offer an explanation of why the prescribed Diazepam was not utilized to treat Resident #214's anxiety which was indicated as an adverse consequence exhibited by Resident #214 related to the use of antidepressants.

The CAA's analysis of findings dated 07/20/14 focused on Resident #214's use of psychotropic drugs did not contain any information or care plan considerations associated with risk for falls and monitoring changes in sleep patterns related to the use of Remeron to treat insomnia, cognition, behavior, mood, nutritional status, bowel function, ability to engage in ADLs or any other potential adverse consequences related to the use of psychotropic medications. The CAA's analysis of findings dated 07/20/14 focused on Resident #214's use of psychotropic drugs did not contain any guidance concerning gradual dose reduction, evaluation of the effectiveness or proper administration of the prescribed psychotropic medications.

On 05/06/15 at 2:23 PM an interview was conducted with the MDS Coordinator who completed the CAA for Resident #214's use of psychotropic drugs. The MDS Coordinator reviewed the CAA dated 07/20/14 for Resident #214's use of psychotropic drugs and verbalized that she understood it did not contain the required information.

6. Resident #67 was admitted to the facility on 05/06/13. Resident #67's diagnoses included

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cerebrovascular disease, thrombosis, dementia, anxiety, Alzheimer ' s disease and depressive disorder.

MDS annual assessment dated 03/11/15 recorded that Resident #67 had severely impaired cognition, required extensive assistance with bed mobility and personal hygiene and was totally dependent for transfers, dressing and toileting. MDS annual assessment dated 03/11/15 indicated that Resident #67 had received antipsychotic/antidepressant medications 7 of the 7 days preceding the assessment and antianxiety medication 3 of the 7 days preceding the assessment.

Review of the CAA dated 03/11/15 focused on Resident #67's use of psychotropic drugs indicated that Resident #67 was taking antipsychotic, antianxiety and antidepressant medications.

The indicators of psychotropic drug use contained in the psychotropic drug use CAA dated 03/11/15 informed by a check block response only that Resident #67 was exhibiting anxiety as a consequence of antidepressant use, delirium due to the use of antipsychotics and disturbances of balance, gait and positioning ability related to taking anixiolytics. No supporting documentation was provided in the area provided for supporting documentation in Resident #67's CAA dated 03/11/15 to support the check block responses.

The CAA's analysis of findings dated 03/11/15 concerning psychotropic drug use contradicted the information provided in the CAA's indicators of psychotropic drug use referenced above by recording that Resident #67 is not experiencing

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any adverse effects related to the use of psychotropic medications.

The only additional information that was provided in the CAA's analysis of findings dated 03/11/15 concerning psychotropic drug use was that Resident #67 received psychotropic medications daily, a list of the psychotropic medications which were prescribed and the name of the provider who managed Resident #67's psychotropic medications.

The CAA's analysis of findings dated 03/11/15 focused on Resident #67's use of psychotropic drugs did not contain any other information or care plan considerations associated with risk for falls, monitoring changes, cognition, behavior, mood, nutritional status, bowel function, ability to engage in ADLs or any other potential adverse consequences related to the use of psychotropic medications. The CAA's analysis of findings dated 03/11/15 focused on Resident #67's use of psychotropic drugs did not contain any guidance concerning gradual dose reduction or evaluation of the effectiveness of the prescribed psychotropic medications.

On 05/06/15 at 2:23 PM an interview was conducted with the MDS Coordinator who completed the CAA for Resident #67 ' s use of psychotropic drugs. The MDS Coordinator reviewed the CAA dated 03/11/15 for Resident #67's use of psychotropic drugs and verbalized that she understood it did not contain the required information.

7. Resident #26 was admitted to the facility 03/11/15. Resident #26's diagnoses included macular degeneration, chronic/allergic

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conjunctivitis and anxiety disorder.

The Admission Comprehensive Minimum Data Set (MDS) assessment dated 03/25/15 recorded that Resident #26 was cognitively intact and indicated that Resident #26 required extensive assistance with bed mobility, transfers, dressing, toileting and personal hygiene.

CAA summary related to Resident #26's visual function dated 03/18/15 informed by check block response only that Resident #26 had cataracts, glaucoma or macular degeneration accompanied by decreased visual acuity and that Resident #26 experienced difficulty seeing television, reading material of interest or participating in activities of interest because of vision problems. No further information or supporting documentation was provided to support the assessment findings.

CAA summary related to Resident #26's visual function dated 03/18/15 informed by check block response only that Resident #26 was prescribed narcotics which could have impaired Resident #26's vision with no supporting documentation provided other than indicating Resident #26's medication list should be used as a reference.

CAA summary related to Resident #26's visual function dated 03/18/15 indicated by check block only that Resident #26 exhibited a mood or anxiety disorder that could cause visual disturbances without further elaboration or documentation and recorded that Resident #26 did not utilize visual appliances such as reading glasses, distance glasses, contact lens or a magnifying glass.

The CAA's analysis of findings related to

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Resident #26's visual function dated 03/18/15 did not provide any guidance concerning proper care planning and recorded only that Resident had moderately impaired vision without glasses in use and did not reference any other visual appliances, assessments, interventions or consults related to preventing a decrease in or improving Resident #26's visual acuity.

A staff interview was conducted 05/06/2015 at 2:40 PM with the facilities SW who had prepared the CAA summary related to Resident #26's visual function dated 03/18/15. The SW verbalized that her understanding of what was required on a CAA summary was an indication of the resident's condition and indicated that the information for the CAA summaries was located in her MDS notes. The SW reviewed Resident #26's MDS data and was unable to provide any further information concerning Resident #26's visual function. The SW reported that she did not know that a CAA was supposed to contain indicators, causes, contributing factors and risk factors related to a resident's care and a summary of the resident's strengths, weaknesses, history and prognosis in the analysis of findings.

8. Resident #19 was admitted to the facility 03/16/15. Diagnoses included idiopathic neuropathy and chronic pain.

The admission Minimum Data Set (MDS) dated 03/26/15 indicated Resident #19 was cognitively intact, was receiving hospice care, and felt frequent pain that limited day-to-day activities. Review of the Care Area Assessments (CAA) revealed the care area of pain had triggered for further consideration by the care plan team.

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Review of the care plan dated 04/01/15 identified a problem area of hospice care, including goals and interventions to help the resident manage pain.

Review of the medical record revealed Resident was prescribed pain medication as needed and had been receiving the pain medication as requested and prescribed.

Review of the CAA Summary for Pain dated 03/26/15 revealed Resident #19 triggered due to answers on the Pain Assessment in the MDS. The CAA included no description for characteristics of the resident's pain, including location, type, onset, and duration. In addition, there was no supporting documentation. The CAA indicated Resident #19's pain limited day-to-day activities and limited independence with at least some activities of daily living but did not include any supporting documentation. There was no resident, family, or representative input documented. The analysis of findings did not include risk factors related to pain.

An interview was conducted with the MDS Coordinator on 05/06/15 at 2:21 PM. She stated she tried to give a picture of the resident in the CAA and should include strengths, weaknesses, and a detailed analysis of the findings. She explained the Pain CAA for Resident #19 did not give a clear picture of the resident's pain or analysis.

9. Resident #129 was readmitted to the facility on 03/13/15. Diagnoses included Stage I kidney disease, prostatic hypertrophy, and neurogenic bladder.

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| F 272 | Continued From page 19<br><br>Review of the most recent comprehensive annual Minimum Data Set (MDS) dated 07/01/14 revealed Resident #129 was cognitively intact and had an indwelling urinary catheter. Review of the Care Area Assessments (CAA) revealed the care area of urinary incontinence and indwelling catheter had triggered for further consideration by the care plan team.<br><br>Review of the CAA Summary for Urinary Incontinence and Indwelling Catheter dated 07/01/14 revealed modifiable factors of medications, psychological conditions, pain, and restricted mobility but no supporting documentation. There was also no supporting documentation for Resident #129's contributing diagnoses or prescribed medications. There was no resident, family, or representative input documented. The analysis of findings did not include a description of the problem, contributing factors, or risk factors related to indwelling urinary catheter use.<br><br>An interview was conducted with the MDS Coordinator on 05/06/15 at 2:21 PM. She stated she tried to give a picture of the resident in the CAA and should include strengths, weaknesses, and a detailed analysis of the findings. She explained the Urinary Incontinence and Indwelling Catheter CAA for Resident #129 did not give a clear picture of the resident's indwelling catheter use or analysis. | F 272 | | |
| F 364 SS=D | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP<br><br>Each resident receives and the facility provides food prepared by methods that conserve nutritive | F 364 | | 6/2/15 |

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| F 364 | Continued From page 20<br>value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff and resident interviews, record review and tasting of foods served on a requested test tray the facility failed to serve hot lunch foods that were palatable for 2 of 5 sampled residents (Resident #107 and #52).<br><br>The findings included:<br><br>1. Resident #107 was admitted to the facility on 03/03/15 with diagnoses that included weakness, obesity, heart failure and others. The most recent Minimum Data Set (MDS) dated 03/17/15 specified the resident's cognition was intact.<br><br>On 04/30/15 at 12:34 PM Resident #107 was interviewed and reported that her food was not served at the proper temperature.<br><br>On 05/05/15 at 1:10 PM Resident #107 was served her lunch tray. The resident was interviewed and reported that the temperature of her food was "okay" and added it could be hotter.<br><br>On 05/05/15 at 1:13 PM the hot foods served on a requested lunch test tray were tasted with the facility's Dietary Manager (DM). Tasting of the test tray's pork loin and mashed potatoes revealed these foods were barely warm. Observations of butter placed on the mashed potatoes and green peas revealed the food was not hot enough to melt the butter. Interview with the facility's DM during the tasting of the foods | F 364 | Affected Resident:<br><br>Resident #107 and Resident #52 interviewed concerning preference in food temps.<br><br>Potentially Affected Resident:<br><br>All residents have the potential to be affected. 100% of interviewable residents interviewed concerning preference in food temps.<br><br>No concerns noted.<br><br>Measures/Systemic Changes:<br>Nursing staff in-serviced on serving food at proper/prefer temperature to include: timeliness of passing trays to residents on hall.<br><br>Dietary Cooks in-serviced on serving food at proper/prefer temperature to include: timely food preparation (tray line start time was changed) & timely delivery of trays to halls.<br><br>Monitoring:<br><br>Monitoring tool developed to monitor food temperature preference. | |

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| F 364 | Continued From page 21<br>served on the test tray, revealed the DM felt the foods were not acceptable. The facility's DM was interviewed and reported that she was aware of residents' complaints of cold food and addressed individual complaints with residents and encouraged them to eat meals in the dining room.<br><br>2. Resident #52 was admitted to the facility on 12/16/14 with diagnoses of diabetes and heart failure. The quarterly Minimum Data Set dated 04/09/15 revealed Resident #52 was cognitively intact.<br><br>An interview was conducted on 04/30/15 at 12:27 PM with Resident #52. She stated the food was cold at every meal.<br><br>On 05/05/15 at 1:06 PM Resident #52 was served her lunch tray. She stated her peas and chopped pork were cold and her mashed potatoes were just warm.<br><br>On 05/05/15 at 1:13 PM the hot foods served on a requested lunch test tray were tasted with the facility's Dietary Manager (DM). Tasting of the test tray's pork loin and mashed potatoes revealed these foods were barely warm. Observations of butter placed on the mashed potatoes and green peas revealed the food was not hot enough to melt the butter. Interview with the facility's DM during the tasting of the foods served on the test tray, revealed the DM felt the foods were not acceptable. The facility's DM was interviewed and reported that she was aware of residents' complaints of cold food and addressed individual complaints with residents and encouraged them to eat meals in the dining room. | F 364 | Dietary Manager (or Administrator) to conduct weekly audits of 10% of residents for 4 weeks, then 10% of residents every 2 weeks for 4 weeks, then monthly for 2 months. Continued audits will be determined based on results of prior 4 months of audits.<br><br>All results will be reviewed monthly during QAPI meeting for a minimum of 4 months. | |

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| L410 | .3201(K) Required Spaces<br><br>10A-13D. 3201(k) A toilet room shall be directly accessible from each patient room and from each central bathing area without going through the general corridor. One toilet room may serve two patient rooms but not more than eight beds. The lavatory may be omitted from the toilet room if one is provided in each patient room. One tub or shower shall be provided for each 15 beds not individually served. There shall be at least one bathtub accessible on three sides and one shower provided for each 60 beds or fraction thereof.<br><br>This Rule is not met as evidenced by:<br>Based on observations and staff and resident interviews, the facility failed to provide a bathtub for every 120 residents.<br><br>The findings included:<br><br>Peak Resources of Gastonia is licensed for 120 beds.<br><br>Resident #78 was admitted to the facility on 01/18/13. Diagnoses included osteoarthrosis and idiopathic neuropathy.<br><br>An annual Minimum Data Set dated 01/16/15 indicated Resident #78 was moderately cognitively impaired and required total assistance of one staff member for bathing.<br><br>An initial tour of the facility on 04/30/15 beginning at 10:09 AM revealed no bathtub was present in any of the facility's four shower rooms. | L410 | Affected Resident:<br><br>Quotes and Specs received and reviewed by Maintenance Director.<br><br>Order placed for bathtub.<br><br>Expected arrival of bath tub is 6/22/2015.<br><br>Expected completion of installation of bath tub is 6/24/2015.<br><br>Resident #78 interviewed and bathing preferences updated to include the option of taking a bath.<br><br>Potentially Affected Resident:<br><br>Quotes and Specs received and reviewed by Maintenance Director.<br><br>Order placed for bath tub. | 6/24/15 |



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

Electronically Signed | 05/30/15

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NH0402 | A. BUILDING: _____ B. WING _____ | C 05/06/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| PEAK RESOURCES - GASTONIA | 2780 X-RAY DRIVE GASTONIA, NC 28054 |

| (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) COMPLETE DATE |
|---|---|---|---|---|
| L410 | Continued From page 1<br><br>An interview was conducted with Resident #78 on 04/30/15 at 3:20 PM. She stated she would prefer to take a bath but was only offered a shower.<br><br>An interview was conducted with Nurse Aide (NA) #1 on 05/05/15 at 12:48 PM. She stated residents were offered showers or bed baths on admission. She explained residents were not offered tub baths because the facility did not have a bathtub in which to bathe residents.<br><br>An interview was conducted with the Administrator on 05/05/15 at 1:24 PM. She stated the facility had not had a bathtub since she had become administrator about four years ago. She explained she was unaware of the requirement for the facility to have a bathtub but would look into having one installed. The Administrator was employed at this nursing home in 2011. | L410 | Expected arrival for bath tub is 6/22/2015.<br><br>Expected completion of installation of bath tub is 6/24/2015.<br><br>100% of residents and/or representatives will be interviewed and bathing preferences updated for all residents who prefer a bath.<br><br>Measures/Systemic Changes:<br><br>The option of taking a bath was added to our current system for bathing preferences.<br><br>Bathing preferences will continue to be reviewed upon admission and as needed per resident request. For residents unable to communicate preference, the resident's representative will be interviewed for bathing preference.<br><br>All staff in-serviced regarding addition of bath being a choice of bathing preference. Review of current communication system of bathing preferences.<br><br>Monitoring:<br><br>A monitoring tool was developed to monitor residents bathing preferences to include, but not limited to: Do you receive a shower/bath per your preference? ; If you have preferences that need to be addressed, do you know who to talk to?<br><br>ADON (or Administrative Nurse) to conduct weekly audits of 10% of residents | |

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|---|---|---|---|---|
| L410 | Continued From page 2 | L410 | for 4 weeks, then 10% of residents every 2 weeks for 4 weeks, then 10% of residents monthly for 2 months. Continued audits will be determined based on results of prior 4 months of audits.<br><br>Audit results will be reviewed during monthly QAPI meeting for a minimum of 4 months. | |