STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. BUILDING _____ B. WING _____	C 07/30/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - SHELBY	**1101 NORTH MORGAN STREET SHELBY, NC 28150**

(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 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for	F 203		8/18/15

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

Electronically Signed | 08/18/2015

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F 203	Continued From page 1 nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to issue a 30 day discharge notice to one of one sampled resident(#171)reviewed for discharge. Findings included: Resident #171 was admitted to the facility on 5/11/2015. The active diagnoses included Lack of Coordination, Hypertension, Cerebrovascular Accident and Anxiety Disorder. A review of the Minimum Data Set dated 5/18/2015 revealed Resident #171 was cognitively intact and required extensive assistance for bed mobility and transfer. He had no hearing deficit; was able to communicate his needs; had behaviors during the 7 day look back period; that included verbal behavior symptoms directed toward other. A review of a progress note dated 5/18/2015 revealed Resident #171 was admitted to the facility for short term therapy and was alert and oriented to person, place, and time. Resident	F 203	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that the alleged deficiencies did, in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the requirements and to provide high quality care. 1. Resident #171 no longer resides at the facility. 2. For those with potential: A) An audit tool was developed on 08/13/2015, which addresses the discharge process. This tool includes, but is not limited to; Notice of transfer/discharge in writing, location being transferred/discharged to, the right to appeal, etc. B) All resident discharged in the last 60 days were reviewed/audited for compliance with appropriate discharge procedures. This has been accomplished by the Director of Nursing, Staff Development Coordinator, and the Clinical	

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F 203	Continued From page 2 #171 reported to the Social Service Director (SSD) he did not feel depressed or anxious but felt like he was a failure because he needed so much help. The SSD noted that on 5/15/2015, Resident #171 refused therapy, had multiple episodes of yelling at staff and stating that no one helped him despite staff answering his call light often. Resident #171 got irritated, yelled out at staff, bang his call light and remote on the table for attention. During an interview with the Resident #171 in the presence of the family. The SSD included in her progress note that during an interview with the resident, in the presence of the family, the SSD encouraged the resident to be cooperative with therapy and staff so that he may regain some of his prior function. A review of Social Services Progress Note dated 5/19/2015 revealed that no discharge date had been set. A review of Social Services Progress Note dated 5/21/2015 at 12:49pm (Recorded as late Entry on 5/22/2015 at 12:53PM) revealed that Resident #171 was discharged home today [5/21/2015]. The SSD wrote in her progress note that she explained to the RP (responsible party) that Resident #171 was no longer an active participant in therapy. Resident #171 yelled, screamed, and demanded to go home and was not redirectable. The family reported to the SSD that they would come and get Resident #171 but needed transportation home. SSD set up transportation for Resident #171. Resident #171 family brought his personal wheelchair to the facility so he could be transferred. All discharge paperwork was reviewed and medications were sent home. RP (responsible party) stated she will call the physician office on 5/22/2015 to set up a follow up	F 203	Care Coordinator. 3. Systemic Changes: A) An in-service will be completed on 08/19/2015 for staff members who are involved in the discharge process. For those staff members who are on a leave of absences or who are otherwise out of the facility, the in-service will be completed prior to returning to their assignment. B) All transfers/discharges are discussed daily in the Administrative meeting and weekly with the therapy manager or designee. Any changes in planned transfers/discharges will be communicated with the appropriate interdisciplinary involvement as they occur. 4. Monitoring for future compliance: A) Will be done by auditing discharges with the newly developed tool as follows: 100% of all residents transferred/discharged will be reviewed for four weeks, 50% of all residents transferred/discharged will be reviewed for four weeks, and 25% of all residents transferred/discharged will be reviewed for four weeks. B) Ongoing audits will be determined by the results of the prior audits. 5. Completion of audits will be November 6, 2015. Results of the audits will be reviewed at the monthly QAPI meeting and weekly in the Administrative Nursing meetings. Changes in the Performance Improvement Plan will be accomplished when necessary.	

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F 203	Continued From page 3 appointment for Resident #171. A review of Social Services Progress Note dated 5/21/2015 at 2:29pm revealed that Resident #171 will be discharged home today. Resident #171 refused to get out of bed for therapy, yelling, verbally aggressive, physically aggressive with staff. Referral made for Home Health to follow Resident #171. SSD wrote "SSD attempted to make follow up appointment but the physician office was closed." During an interview with the SSD on 7/30/2015 at 2:00pm she revealed she called Resident # 171 ' s family and informed them that Resident #171 had been refusing physical therapy and that he needed to be discharged. The SSD indicated she informed Resident #171's family that he could be discharged on 5/22/2015. The family informed the SSD that he would be picked up today (5/21/2015). The SSD also stated that she followed the policy for discharging a Resident #171 because Resident # 171 was only here for short term. On 7/30/2015 at 2:35 PM an interview with the therapy department revealed that Resident #171 was not discharged from therapy services. The therapy department was made aware of resident #171 ' s discharge at his next scheduled appointment. During an interview with the Director of Nursing (DON) on 7/30/2015 at 3pm she revealed her expectation would be that the SSD would follow the facility discharge policy for all residents. Her expectation would include proper notification and communication between disciplines and departments. The DON indicated that she would	F 203		

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F 203	Continued From page 4 have to review the policy information herself. The DON also indicated that she would check on the Notice of Non-Coverage letter for Resident #171.	F 203		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. 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 State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on record review, home health agency and staff interviews the facility failed to provide a safe/orderly discharge for to one of one sample resident # (171) reviewed for discharge. Findings included: Resident #171 was admitted to the facility on 5/11/2015 the active diagnoses included Lack of Coordination, Hypertension, Cerebrovascular Accident and Anxiety Disorder. A review of the Minimum Data Set dated 5/18/2015 revealed Resident #171 was cognitively intact and required extensive assistance for bed mobility and transfer. He had	F 204	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that the alleged deficiencies did, in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the requirements and to provide high quality care. 1. Resident #171 no longer resides at the facility. 2. For those with potential: A) An audit tool was developed on 08/13/2015, which addresses the preparation for safe/orderly discharge process. This tool includes but is not	8/18/15

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F 204	Continued From page 5 no hearing deficit; was able to communicate his needs; had behavior during the 7 day look back period; that included other verbal behavior symptoms directed toward other and other behavioral symptoms not directed toward others. A review of a progress note dated 5/18/2015 revealed Resident #171 was admitted to the facility for short term therapy and was alert and oriented to person, place, and time. Resident #171 reported he does not feel depressed or anxious but felt like he was a failure because he needs so much help. The Social Service Director (SSD) and family, who was present for an interview, encouraged Resident #171 to be cooperative with therapy and staff so that he may regain some of his prior function. On 5/15/2015, Resident #171 refused therapy, had multiple episodes of yelling at staff and stating that no one helped him despite staff answering his call light often. Resident #171 got irritated yelled out at staff, bang his call light and remote on the table for attention. A review of Social Services Progress Note dated 5/19/2015 revealed that no discharge date had been set. A review of Social Services Progress Note dated 5/21/2015 at 12:49pm (Recorded as late Entry on 5/22/2015 at 12:53PM) revealed that Resident #171 was discharged home today [5/21/2015] rather than 5/22/2015. The SSD explained that Resident #171 was no longer an active participant in therapy. Resident #171 yelled, screamed, and demanded to go home and was not redirectable. The family reported to the SSD that they would come and get Resident #171 but needed transportation home. SSD set up transportation	F 204	limited to; Notice of transfer/discharge in writing, location being transferred/discharged to, and the right to appeal, involvement in local adult protective services, etc. B) All resident discharged in the last 60 days were reviewed/audited for compliance with appropriate discharge procedures. This has been accomplished by the Director of Nursing, Staff Development Coordinator, and the Clinical Care Coordinator. 3. Systemic Changes: A) An in-service will be completed on 08/19/2015 for staff members who are involved in the discharge process. For those staff members who are on a leave of absences or who are otherwise out of the facility, the in-service will be completed prior to returning to their assignment. B) All transfers/discharges will be discussed daily in the Administrative meeting and weekly with the therapy manager and/or designee. Any changes in planned transfers/discharges will be communicated with the appropriate interdisciplinary involvement as they occur. C) For residents and/or family representatives who wish to change scheduled transfer/discharge dates, the following will be put into place: interdisciplinary team meeting, notification of the local adult protective services, notification to local Ombudsman if indicated, and coordination of services with local Home Health agency of choice. 4. Monitoring for future compliance:	

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F 204	Continued From page 6 for Resident #171. Resident #171 family brought his personal wheelchair to the facility so he could be transferred. All discharge paperwork was reviewed and medications sent home. RP (responsible party) stated she would call the physician office on 5/22/2015 to set up a follow up appointment for Resident #171. A review of Social Services Progress Note dated 5/21/2015 at 2:29pm stated (in part) that Resident #171 would be discharged home today. Resident #171 refused to get out of bed for therapy, yelling, verbal aggressive, physically aggressive with staff. Referral made for Home Health to follow Resident #171. SSD attempted to make follow up appointment but the physician office was closed. During an interview with a representative of the home health agency on 7/29/2015 she revealed that the procedure for the discharge of Resident #171 was not followed. The home health agency did not received a referral from the facility until after Resident #171 was discharged on 5/21/2015. The representative indicated the policy for Home Health services included: before discharge a Home Health staff member would come out to the facility and assess the resident for services. The representative indicated that a facility assessment was not done on Resident #171. The representative also indicated that she received a phone call and request for advice from Resident #171 family before she completes an initial assessment or first visit to Resident #171 's home. She also indicated that home health services were not started within 48 after Resident #171 was discharged due to the unplanned referral from the facility. During an interview with the SSD on 7/30/2015 at	F 204	A) Will be done by auditing discharges with the newly developed tool as follows: 100% of all residents transferred/discharged will be reviewed for four weeks, 50% of all residents transferred/discharged will be reviewed for four weeks, and 25% of all residents transferred/discharged will be reviewed for four weeks. B) Ongoing audits will be determined by the results of the prior audits. 5. Completion of audits will be on November 6, 2015. Results of the audits will be reviewed a monthly QAPI meeting and weekly in the Administrative Nursing meetings. Changes in the Performance Improvement Plan will be accomplished when necessary.	

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F 204	Continued From page 7 2pm she revealed she called Resident #171's family and informed them that Resident #171 had been refusing physical therapy and that he needed to be discharged. The SSD indicated she informed Resident #171 ' s family that he could be discharged on 5/22/2015. The family informed the SSD that he would be pick up today (5/21/2015). The SSD also stated that she followed the policy for discharging a Resident #171 because Resident #171 was only here for short term. On 7/30/2015 an interview with the therapy department revealed that Resident #171 was not discharged from therapy services. The therapy department was made aware of resident #171's discharge at his next scheduled appointment. During an interview with the Director of Nursing (DON) on 7/30/2015 at 3pm she revealed her expectation would be that the SSD would follow the facility discharge policy for all residents. Her expectation would include proper notification and communication between disciplines and departments. The DON indicated that she would have to review the policy information herself.	F 204		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		8/18/15

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F 309	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to follow physician recommendation and schedule a follow up orthopedic appointment for 1 of 1 resident (Resident #188) with a fractured humerus and splint. Findings included: Resident #188 was admitted to the facility on 3/28/2014 and discharged to an acute care hospital on 2/28/2015. Her diagnosis included Breast Cancer, Muscle Weakness, Vitamin D deficiency, and Anxiety. The Minimum Data Set dated 4/4/2014 revealed Resident #188 was moderately cognitively impaired. She required extensive assistance from staff with 2 person physical assistance for bed mobility, transfers. A record review on 11/25/2014 revealed Resident #188 complained of right arm and shoulder pain. On 11/25/2014 a mobile x-ray report included a comminuted fracture [shatters into three or more pieces] of the right humerus [long bone of the upper arm]. Record review revealed a complete facility investigation dated 11/26/2014. Resident #188 complained of pain to her right arm and right shoulder. Staff statements reported nothing unusual occurred for Resident #188. The staff used a sit to stand mechanical lift for transfers. A mobile x-ray revealed a right humerus fracture. Resident #188 was sent to orthopedics. An orthopedic consultation dated 11/26/2014 revealed a right humerus fracture and a recommendation of follow up in 1 to 2 weeks. An orthopedic consultation dated 12/4/2014 revealed findings of status post right humerus fracture waxing/waning pain getting better. Hand very swollen. Recommendations keep splint in	F 309	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider that the alleged deficiencies did, in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the requirements and to provide high quality care. 1. Resident #188 no longer resides at the facility. 2. For those with potential: A) An audit tool was developed on 08/13/2015, which address the process of scheduling follow up appointments outside of facility. This includes, but is not limited to; origin of order, family notification, and if the resident went to the appointment. B) All resident appointments for the last 30 days were reviewed/audited to see if they were attended by the resident. The Director of Nursing, Staff Development Coordinator, and the Clinical Care Coordinator completed this audit. C) 100% of consults for resident for last 30 days were reviewed/audited to see if the ordered follow up appointments were made by staff and attended by the resident. D) New appointment log was developed with the following information; date, resident¿s name, ordering physician, appointment needed (including time frame), family notification, and was the appointment attended by resident or cancelled.	

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F 309	Continued From page 9 place and follow up in 3 weeks. A nurse note dated 12/10/2014 revealed the orthopedic office called to confirm an appointment scheduled at 1:00 PM. [This was 6 days after Resident #188 ' s scheduled follow up appointment.] The nurse note included the nurse received a call from a family member concerned about the swelling of Resident #188 ' s right hand. The responsible party (RP) was contacted and she was not aware of the appointment. Resident #188 was assessed and the swelling was not a new issue. The RP was made aware that the orthopedic appointment was not made by the facility and the RP requested cancellation of the appointment. A record review of the facility EMR (electronic medical record) resident appointment log for the months of December 2014, January 2015, and February 2015 did not include an orthopedic follow up appointment for Resident #188. On 7/30/2015 at 2:50 PM an interview with the staff member who was the ward clerk when Resident #188 was in the facility revealed the procedure for scheduling resident appointments. The nurse staff wrote the order or referral in the appointment book " blue book " or made a copy and placed it in the appointment book. She reported she referred to her appointment book and if there was an appointment to be made then she made it. The ward clerk reported she did not save the hand written log from December 2014. January 2015 and February 2015 were reviewed and there was no entry/referral for Resident #188 to be scheduled for an orthopedic follow up. The ward clerk reported there was a problem with the nursing staff pinning up referrals at her work station and not putting them in the appointment book causing appointments to not be scheduled. On 7/30/2015 at 2:58 PM An interview with Nurse	F 309	3. Systemic Changes: A) A new process for appointments was developed that included the following; a) upon admission, the information packet will be reviewed by the Clinical Care Coordinator/Charge nurse for the necessary appointments and logged on newly created form. For established residents, with any change of condition that requires the resident to go out for medical services, and/or physician orders, the information will also be reviewed by the Clinical Care Coordinator/Charge Nurse and logged, b) this log will be checked daily by the staff member assigned to make appointments, and by the Clinical Care Coordinator/Charge Nurse to ensure compliance with scheduled appointments. B) In the event of a cancelled appointment by staff, resident, and/or family representative, the Clinical Care Coordinator/Charge Nurse, will communicate with the consulting doctor¿s office for an appropriate follow up appointment time. The new appointment will then be logged for monitoring. C) With cancellations, the following information will be noted in the resident¿s progress notes; the person who cancelled the appointment, the notification of family representative, the new follow up appointment and any other relevant information. D) If a family representative and/or resident refuses to attend and/or cancels the same appointment twice, appropriate interventions will be care planned to include, but not limited to, assistance from	

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PEAK RESOURCES - SHELBY	**1101 NORTH MORGAN STREET SHELBY, NC 28150**

(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 309	Continued From page 10 #1 a supervising nurse revealed the nursing staff dropped the referral paperwork with the charge nurse. She reported she was the 1st shift charge nurse when Resident #188 was in the facility and the charge nurse was to receive the office visit paperwork [communication tool from physician including referral recommendations] from the nursing staff when a resident returned to the facility. The charge nurse was responsible for transcribing the physician orders, recommendations for referrals, and follow up appointment in the appointment [blue] book. Nurse #1 was unable to locate a scheduled orthopedic follow up appointment for Resident #188 as recommended by the orthopedic physician on her 12/4/2014 appointment. A record review of the orthopedic office appointment log for Resident #188 included: appointment on 11/26/2014 status arrived, 12/4/2014 status arrived, 12/10/2014 status canceled, and 3/4/2015 status canceled. An interview on 7/30/2015 at 3:20 PM with the Director of Nursing revealed she expected physician orders to be reviewed by the nursing staff and collaborate with the scheduling staff in the event appointments are not scheduled or cancelled so the facility could communicate with the families. The DON reported the facility had an " appointment to be made book. " It was not acceptable to pin or tack resident referrals or orders on the wall. The DON ' s expectation was for the staff to follow the procedure for scheduling resident appointments.	F 309	Social Services Director, Ombudsmen, and Adult Protective Services if indicated. E) Nursing Staff and any interdisciplinary staff involved with scheduling consults and follow up appoints will be in serviced by 08/18/2015 for this new process. For those staff members who are on leave of absences or who are otherwise out of the facility, the in-service will be completed prior to returning to their assignment. 4. Monitoring for future compliance: A) Will be done by auditing consult orders with the newly developed audit tool as follows: 100% of consults for four weeks, 50% of consults for four weeks, 25% of consults for four weeks. B) Ongoing audits will be determined by the results of the prior audits. 5. Completion of audits will be November 06, 2015. Results of the audits will be reviewed at monthly QAPI meeting and at the weekly Administrative Nursing Meetings. Changes in the Performance Improvement Plan will be accomplished when necessary.	