STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-OUTER BANKS	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 000	INITIAL COMMENTS No deficiencies cited as a result of of the complaint investigation conducted on 4/14/16. Event ID EU3Y11.	F 000		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff, the facility failed identify a significant change in status for 1 of 3 (Resident #43) residents reviewed for Activities of Daily Living (ADLs). The findings included: Resident #43 had been admitted to the facility on 1/21/2015. His diagnoses included Parkinson's disease, diabetes, dysphagia, difficulty with walking and generalized weakness. Resident #43's most recent annual Minimum Data Set (MDS) assessment was dated 1/01/2016 and indicated the resident required	F 274	Filling of this Plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This 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. F274 Affected Resident: Significant change for resident #43 will be completed and submitted by 05/05/2016.	5/12/16

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

Electronically Signed | 05/04/2016

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F 274	Continued From page 1 limited assistance with locomotion on and off the nursing unit and set up assistance with eating. The assessment also indicated Resident #43 was frequently incontinent of urine. A quarterly MDS assessment dated 2/05/2016 indicated Resident #43 had been ambulatory in the hall with extensive assistance, had required limited assistance with locomotion on and off the nursing unit and required set up and supervision with eating. The assessment also indicated Resident #43 was frequently incontinent of urine. Resident #43's most recent quarterly MDS assessment was dated 3/01/2016 and indicated the resident required total assistance with locomotion on and off the nursing unit, and extensive assistance with eating. The assessment also indicated Resident #43 required the use of an indwelling urinary catheter. The assessment also indicated Resident #43 had received intravenous (IV) medications while a resident. Record review indicated Resident #43 had been hospitalized from 2/24/2016 through 2/26/2016. Hospital discharge diagnoses included urinary tract infection (UTI) and urinary retention. An interview with Nurse #1 was conducted on 4/13/2016 at 11:50 AM. The nurse stated about one month ago Resident #43 had become very ill with a urinary tract infection and had required increased assistance with his care. The nurse stated he had improved since that time and was back to his previous level of care. The nurse also stated the Resident no longer required the use of an indwelling urinary catheter. The nurse also stated the Resident continued to have a long term	F 274	Potentially Affected Resident: For those residents who may be affected the Administrative nurses and Administrator have reviewed the current resident status in comparison to last assessment to assess for a significant change. Residents who were identified as having a significant change, an assessment was opened and will be completed by 05/12/2016. Measures/Systemic Changes: MDS coordinator was educated on 4/25/16 by Mary Maas via telephone related to conducting a comprehensive assessment of a resident within 14 days of a significant change in the residents physical or mental condition. Administrator reviewed RAI on explanation of a significant change with both MDS coordinators. Administrator developed a Whiteboard to identify residents with improve/decline in ADL's and is placed on board in case there is a decline in 2 or more areas that are referenced in the RAI chapter 2: Assessment. This is reviewed every morning during the week with clinical staff. Education was approved by Regional Nurse consultant. Monitoring: A monitoring tool was developed to monitor for a significant change in 2 or more areas that would call for a comprehensive assessment. Administrator or Administrative nurse designee to conduct a random sample of 10% of residents to review for a significant	

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F 274	Continued From page 2 IV access in place. An interview with nurse aide (NA) #2 was conducted on 4/13/2016 at 4:43 PM. The NA stated Resident #43 required frequent incontinent care and was always incontinent of bowel and bladder. An interview with Nurse #2 was conducted on 4/14/2016 at 10:39 AM. The nurse stated she had cared for Resident #43 for at least one year. The nurse stated Resident #43's ability to transfer had declined from being able to use a sit to stand lift to requiring the use of a total lift. The nurse stated the Resident had been able to ambulate in the halls with the restorative nurse aids and propel himself short distances in the wheelchair and now required assistance with mobility. The nurse further stated Resident #43 no longer used an indwelling urinary catheter. The nurse stated Resident #43 continued to receive IV antibiotics for UTI. An interview with the MDS nurse was conducted on 4/14/2016 at 2:50 PM. The MDS nurse stated significant change in status assessments are completed when a resident is not expected to improve in their condition within the next 14 days. The MDS nurse stated Resident #43 had become very ill with a urinary tract infection and had been hospitalized and had required more assistance at the time of the assessment. The nurse stated a significant change in status had not been done for Resident #43 because he is better now. The nurse indicated the most recent MDS did not accurately reflect the resident's current status. An interview with the DON and the Administrator on 4/14/2016 at 4:45 PM was conducted. The	F 274	change weekly 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. Audit results will be reviewed monthly during QAPI meeting for a minimum of 4 months.	

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F 274	Continued From page 3 Administrator stated it was her expectation that MDS assessments should be accurate and reflect the residents' level of care.	F 274		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff	F 278	Filling of this Plan of correction does not	5/12/16

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F 278	Continued From page 4 the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 (Resident # 21) resident reviewed for dialysis, for 1 of 1 (Resident # 96) reviewed for level II Preadmission Screening and Resident Review (PASRR) and for 1 of 4 (Resident # 121) residents reviewed for weight loss. The findings included: 1) Resident #21 was admitted to the facility on 2/3/16 and readmitted on 2/26/16. His diagnoses included End Stage Renal Disease requiring Hemodialysis, Diabetes, Peripheral Vascular Disease and a Right Above Knee Amputation. A review of the MDS dated 3/25/16, a quarterly review, revealed Section O titled Special Treatments, Procedures, and Programs did not have Dialysis marked. An interview was conducted on 4/14/16 at 2:50 PM with the MDS nurse. She stated it was her responsibility to complete Section O. She stated she missed including his dialysis diagnosis in that section. 2) Resident #96 was admitted to the facility on 10/23/15 with diagnoses which included chronic obstructive pulmonary disease, unspecified mental disorder, major depressive disorder, diabetes and obesity. A review of the MDS dated 10/30/15 revealed in Section A under the title of Level II Preadmission Screening and Resident Review conditions did not have any area checked. A review of the Face Sheet for Resident #96 revealed a PASRR number which ended in the letter B. An interview was conducted with the Admissions Coordinator on 4/14/16 at 12:32 PM. He stated Resident #96 was admitted from a hospital outside of North Carolina (NC) so he had to get the PASRR for NC. He stated the resident was a PASRR level II and he had to get a temporary	F 278	constitute an admission that the deficiencies alleged did, in fact, exist. This 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. F278 Affected Residents: Assessments for the following residents (#21, #96, #121) modified. Updates made to accurately reflect the resident. Resident #21 discharged from facility on 04/14/16. Potentially Affected Resident: Administrator and MDS coordinator audited all residents currently in facility to ensure all dialysis, PASRR's and weight loss/gain since the last MDS assessment are coded accurately. No other residents were identified to lack documentation regarding dialysis, PASRR's and weight gain/loss. Measures/Systemic Changes: Administrator educated all IDT members on accuracy of coding on 05/02/2016, this education was approved by Regional MDS consultant. MDS coordinators educated on utilizing CareWatch export for accuracy as a standard practice to review flags. CareWatch serves the long-term care industry with quality improvement systems to reinforce evidence-based care, reduce risk, and enhance organizational performance. If there is a discrepancy from one assessment to the next or missing	

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F 278	Continued From page 5 approval prior to admission. He stated the resident was evaluated by the state agency and now had the letter B certification. An interview was conducted with the MDS Coordinator on 4/14/16 at 3:11 PM. She stated she had not received the information about Resident #96 PASRR information until after the due date for the MDS. She was instructed to send the MDS without the information to avoid the MDS being tardy. 3) Resident #121 was admitted to the facility on 3/25/16 with diagnoses that included pressure ulcers, chronic obstructive pulmonary disease and hypertension. Review of the facility's weight record indicated on 3/26/16, Resident #121's weight was recorded as 173.8 pounds. On 3/31/16, his weight was recorded as 163.75 which represented a 10 pound weight loss in 5 days. The 4/1/16 Admissions Minimum Data Set (MDS) identified the resident as moderately cognitively impaired, but did not identify a 5% weight loss in 30 days or a 10% weight loss in 60 days for Resident #121. Resident #121 was interviewed on 4/13/16 at 12:15 PM. The resident stated he had lost approximately 20 pounds prior to his March 2016 hospitalization and then an additional 40 pounds during the 4 weeks of his hospitalization. Nursing Assistant (NA) #1 was interviewed on 4/13/16 at 2:35 PM. The NA stated Resident #121 was alert, oriented and reliable in the information he provided. On 4/13/16 at 3:00 PM, the Treatment Nurse was interviewed. She stated she had met Resident #121 prior to his admission, and while she had not noticed any weight loss since admission, she	F 278	information, then this system flags the information for us prior to submitting. Monitoring: A monitoring tool was developed to monitor PASSR's, Dialysis, weight loss/gain, and supporting diagnosis. MDS Coordinator or designee will review CareWatch export for flags as an ongoing process. MDS coordinator or designee will utilize monitoring tool and will audit new admissions weekly for 16 weeks. Continued audits will be determined based on results of prior 4 months of audits. Audit results will be reviewed monthly during QAPI meeting for a minimum of 4 months.	

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F 278	Continued From page 6 was aware Residetn #121 had recently lost a lot of weight. The resident, who was described by the treatment nurse as alert, oriented and reliable, had reported to her, the treatment nurse, that he had lost a lot of weight while in the hospital in the 4 weeks prior to facility admission. The Dietary Manager (DM) was interviewed on 4/13/16 at 4:10 PM. She stated she was responsible for coding the nutrition section of the MDS. The DM added she gathered information for MDS completion from the hospital discharge summary and interviews with residents and/or their families. Information for assessment is gathered from hospital discharge summaries or talking with residents and/or families. The DM stated she had not spoken to the resident about his usual body weight or any weight loss prior to completion of the MDS The MDS Coordinator was interviewed on 4/14/16 at 2:50 PM. The MDS nurse stated the DM was responsible for coding the nutritional sections of the MDS.	F 278		
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	F 279		5/12/16

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F 279	Continued From page 7 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 record review and staff interview the facility failed to initiate a comprehensive care plan to address dialysis for 1 of 1 resident (Resident # 21) reviewed for dialysis. The findings included: Resident #21 was admitted to the facility on2/3/16 and reentered on 2/26/16 with diagnoses which included End Stage Renal Disease requiring dialysis, peripheral vascular disease and right above the knee amputation. A medical record review revealed physicians' orders for April 2016 which included "Hemodialysis on Tuesday, Thursday and Saturday." A review of the care plan for Resident #21 revealed it did not address the resident's dialysis. On 4/14/16 at 3:18 PM the MDS nurse coordinator stated she had failed to add dialysis or have the interventions and goals for dialysis to the care plan for Resident #21.	F 279	Filling of this Plan of correction does not constitute an admission that the deficiencies alleged did, in fact, exist. This 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. F279 Affected Residents: Resident #21 had a care plan put in place to address dialysis. No adverse outcomes related to care plan compliance. Potentially Affected Residents: Administrator and MDS coordinator assessed all dialysis resident's care plans to ensure dialysis is being addressed on 04/14/2016. There were no other residents identified with not having an appropriate care plan in place. Measures/Systemic Changes: Administrator educated both MDS coordinators concerning accuracy of completion of care plans related to problematic comorbidities, this was completed on 05/02/2016. This education was approved by the Regional MDS	

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F 279	Continued From page 8	F 279	consultant and consisted of but not limited to the following: function of care plan, individualizing care plans, care plans are a working tool and update the care plans as needed. Monitoring: A monitoring tool was developed on 05/02/2016 to ensure a comprehensive care plan is put in place to address resident's needs to attain or maintain the highest level of function. This audit tool consisted of reviewing timeliness, problem/strength identified, and individualized plan of care. MDS coordinator or designee to conduct weekly audits 10 percent of residents for 4 weeks, then 10 percent of residents every 2 weeks for 4 weeks, then 10 percent of residents monthly for 2 months. Continued audits will be based on results of prior 4 months of audits. Audit results will be reviewed monthly during QAPI meeting for a minimum of 4 months.	