STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345458	A. BUILDING _____ B. WING _____	C 02/16/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - TREYBURN	**2059 TORREDGE ROAD DURHAM, NC 27712**

(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 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 279		3/16/17

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

Electronically Signed | 03/08/2017

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F 279	Continued From page 1 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to develop a plan of care with measurable objectives and timetables to address significant diagnoses for 2 of 5 residents. (Resident #2, #3) Findings included: a) Resident #2 was admitted to the facility on 12/19/16 with readmit date of 1/10/17. Diagnosis included, in part, congestive heart failure, chronic obstructive pulmonary disease, urinary retention, anxiety depression, and asthma. The minimum data set (MDS) dated 1/25/17 14-day assessment revealed the resident was cognitively intact. The resident was coded as	F 279	F- 279 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of the state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicted.	

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F 279	Continued From page 2 having an indwelling Foley catheter and was frequently incontinent of bowel. He was not coded as having a pressure ulcer during this assessment period, but was at risk for pressure ulcers and had a pressure reducing mattress. He was coded as having oxygen. A record review of Resident #2 ' s care plans revealed there were no care plans in place for the urinary catheter, pressure ulcer, chronic obstructive pulmonary disease or congestive heart failure. b) Resident #3 was admitted on 2/6/16. Diagnoses included current bowel infection diabetes, pressure ulcer of unspecified stage, and stroke with left hemiparesis (paralysis/weakness). The MDS information was not completed at the time of this review. A record review revealed a care plan was initiated on 2/7/17 for impaired skin integrity with interventions to include medication and treatments per physician order, pressure reduction mattress, turn and reposition, and to keep clean and dry after each incontinent episode. There was no specific care plan for the existing stage II pressure ulcers, unstageable sacral pressure ulcer, diabetes or the current bowel infection he was being treated for with antibiotics and intravenous fluids. An interview with the MDS/Care plan nurse on 2/16/17 at 4:00 pm confirmed Resident #2 and Resident #3 had significant diagnoses which required a plan of care. She confirmed there was no care plan in place for the specific diagnoses for Resident #2 and Resident #3. The nurse explained when a resident was admitted, their	F 279	Interventions for the affected resident: Resident #2 comprehensive care plan has been reviewed and updated by the RAI team to include pertinent issues related to diagnosis on 3/10/17 Interventions for resident identified as having the potential to be affected: Audit completed on in-house resident for comprehensive care plans on 3/3/17 by the RAI team. Any comprehensive care plans needing updates will be completed by 3/10/17 Systemic Change: MDS staff will be educated on development and timeframes for comprehensive care plans by DON by 3/16/17 Monitoring of the change to sustain system compliance ongoing: DON and nurse management team will review up to 3 new comprehensive care plans weekly x 1 month, then monthly x3 months. Results of audit will be reviewed by the facilities QA committee for additional educational needs or changes to the plan	

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F 279	Continued From page 3 care plans were initiated based on their diagnoses. The nurse further added the interventions should be listed with a time frame of anticipated resolution and measurable goals. The nurse explained during morning meeting if there were any changes in a resident such as an infection, fall, pressure ulcer, etc. it was discussed in the meeting and the care plan would then be updated.	F 279		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to a) provide wound healing supplements and a lab test to determine pre-albumin levels for wound monitoring, and b) to provide pressure ulcer treatments using the prescribed wound orders for 1 of 2 residents. (Resident #3)	F 314	F-314 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of the state	3/16/17

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F 314	Continued From page 4 Findings included: Resident #3 was admitted to the facility on 2/6/16. Diagnoses included, in part, infection in the bowel, diabetes, unstageable pressure ulcer of sacral area, stage II left ischium pressure ulcer, stage II left calf pressure ulcer and a stroke with left hemiparesis. There was no minimum data set information available at this time. A review of Resident #3 ' s care plan initiated on 2/7/17 revealed a plan of care for impaired skin integrity with interventions to include medication and treatments per physician order, pressure reduction mattress, turn and reposition, and to keep resident clean and dry after each incontinent episode. a) A review of a physician ' s order written on 2/7/17 revealed the resident had an order to obtain a lab for pre-albumin (a lab to monitor malnutrition), administer Zinc Oxide 220 milligrams orally daily X 30 days, Vitamin C 500 milligrams orally twice daily for 60 days and Prostat 60 milliliters orally three times daily for wound healing. An interview was conducted with Nurse #1 on 2/15/17 at 2:10 pm. During the interview, the February 2017 Medication Administration Record (MAR) was reviewed with Nurse #1. There were no orders documented for oral supplements for wound healing. Nurse #1 stated the resident was not on any supplements for wound healing. A review of Resident #3 ' s lab work revealed there was no results for the ordered pre-albumin.	F 314	and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by dates indicted. Interventions for the affected resident: Resident #3 Albumin level was done on2/17/17, Physicians orders clarified for wound care on 2/16/17. Interventions for resident identified as having the potential to be affected: Audit completed for lab or supplement needs on residents with pressure wounds. Nurses to review chart for outstanding order transcriptions daily. Nurse management to review new orders in morning clinical meeting. Systemic change: Educate License Nurses on following MD orders for treatments. Educate License Nurses on transcription of physician orders. Monitoring of the change to sustain system compliance ongoing: Random wound care observation for 2 residents weekly x 1 month; then 1 weekly x 2 months, results of audits will be reviewed by the facilities QA committee for additional educational needs or changes to the plan.	

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An interview was conducted with Nurse #1 on 2/16/17 at 9:30 am. Nurse #1 confirmed there were orders written on 2/7/17 for supplements for wound healing as well as a lab order to check the resident ' s pre albumin. Nurse #1 stated the orders for the oral supplements were not transcribed to the MAR nor was the lab order that needed to be obtained for the pre albumin.

An interview with Nurse #2 on 2/16/17 at 3:50 pm revealed she was the nurse who reviewed the orders written by the physician on 2/7/17 for the wound supplements and the lab work. Nurse #2 reported she did not know why she did not transcribe the orders to the MAR and indicated she must have been distracted or pulled away.

An interview with the Director of Nursing (DON) on 2/16/17 at 4:30 pm revealed her expectations of the nurses was to follow and implement any physician orders for wound care treatments.

b) A review of a physician ' s order for the sacral wound written on 2/8/17 revealed to discontinue previous wound orders and to cleanse unstageable ulcer to sacrum with Dakin ' s 0.25%, apply Dakin ' s 0.25% moistened wet to dry sterile dressing twice daily.

A review of a physician ' s order written on 2/8/17 for the stage II left ischium wound revealed to discontinue previous wound orders and to cleanse stage II left ischium with cleanser, pat dry, apply Alginate Ag (a treatment for wounds with increased amount of exudate or fluid) and cover with dry sterile dressing daily and as needed.

A review of a physician ' s order written on 2/8/17

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revealed an order to apply barrier cream to the right ischium every shift and after each incontinent episode.

A review of a physician ' s order written on 2/8/17 revealed an order to discontinue previous wound orders and to cleanse stage II left calf with cleanser, pat dry, apply Alginate Ag and cover with dry sterile dressing daily and as needed.

An observation of the pressure wound dressing treatment was conducted on 2/15/17 at 1:40 pm. Resident #3 was incontinent of stool at this time and incontinent care was provided. Nurse #1 did not apply the prescribed barrier cream to the right ischium at this time. Nurse #1 proceeded with the dressing change to the sacrum. The nurse proceeded to cleanse the necrotic (dead tissue) sacral area with the ordered Dakin ' s 0.25% solution. She moistened the 4X4 gauze with the Dakin ' s 0.25% solution, covered the wound with Alginate Ag and then covered the wound with a dry sterile dressing. Nurse #1 was asked if this was the prescribed order. Nurse #1 reported she would have to check the orders again. Nurse #1 removed the Alginate Ag, checked the order and confirmed there was no Alginate Ag orders for the sacral pressure ulcer. Nurse #1 proceeded to change the dressing on the stage II left ischium. The nurse cleansed the wound with Dakin ' s 0.25% solution, patted dry, applied Alginate Ag to the wound and covered with a dry sterile dressing. Nurse #1 proceeded to change the dressing to the stage II left calf. Nurse #1 cleansed the wound with Dakin ' s 0.25% solution, patted dry, applied Alginate Ag and covered with a dry sterile dressing.

An interview was conducted with Nurse #1 on

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2/15/17 at 2:10 pm. Nurse #1 reported she confused the sacral wound dressing order with the other pressure ulcer orders and that was why she applied the Alginate Ag. Additionally, she reported she forgot to apply the barrier cream to the right ischium as per the order.

An interview was conducted with Nurse #1 on 2/16/17 at 9:30 am. Nurse #1 reported the pressure ulcer treatment orders were unclear regarding the wound cleanser that should have been used on Resident #3. Nurse #1 confirmed the order did not indicate the cleanser to be used was Dakin ' s 0.25%. Nurse #1 stated she did not clarify the order because she thought the Dakin ' s was to be used as the cleanser for all the wound treatments for Resident #3 and that was what she had used since the order was written. Nurse #1 stated she should have clarified the order with the wound nurse.

An interview was conducted with Nurse #2 on 2/16/17 at 3:50 pm. Nurse #2 reported the order for cleansing the wounds should have been clarified because the order did not indicate which kind of cleanser should be used. Nurse #2 stated the Dakin ' s solution was being used since the order was written on 2/7/17.

An interview with the wound nurse on 2/16/17 at 4:13 pm revealed the order for the cleanser to be used for the sacral wound was Dakin ' s 0.25%. The wound nurse stated the cleanser that was ordered for the stage II left ischium wound and the stage II left calf wounds should have been written to use normal saline. The wound nurse stated the order was not clear as to what cleanser should have been used.

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F 314	Continued From page 8 An interview with the Director of Nursing (DON) on 2/16/17 at 4:30 pm revealed her expectations of the nurses was to follow and implement any physician orders for wound care treatments and to clarify any discrepancies they may see in a physician ' s order.	F 314		