STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345494	A. BUILDING _____ B. WING _____	C 02/21/2019

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) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 02/18/19 through 02/21/19. The facility was found in compliance with the requirement CFR 483.73,Emergency Preparedness. Event ID 67J511.	E 000		
F 000	INITIAL COMMENTS There were no deficiencies cited as a result of this complaint investigation survey as of 02/21/19. Event !D # 67J511.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code a fall with a major injury on the Minimum Data Set (MDS) assessment for 1 of 1 resident reviewed for accidents (Resident #61). The findings included: Resident #61 was admitted to the facility on 05/09/18 with diagnoses which included hemiplegia and/or hemiparesis (muscle weakness or loss of muscle function) from cerebrovascular disease affecting an unspecified side. Resident #61 was discharged on 12/08/18 to the hospital and readmitted to the facility on 12/13/18 after receiving surgical repair for a fractured left hip. The hospital discharge summary revealed	F 641	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. Resident # 61 did not experience any adverse effect/no harm related to coding inaccuracy. For resident #61, the MDS dated 12/20/18 was modified by the MDS nurse on 2/20/2019 to show a fall occurred. The MDS coordinator audited all MDS assessments of residents with a fall in the past 30 days to ensure coding accuracy. This audit was completed on 2/22/2019.	3/5/19

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

Electronically Signed | 03/06/2019

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F 641	Continued From page 1 Resident #61 was admitted on 12/08/18 and discharged back to the facility on 12/13/18 after receiving surgical repair for a left hip fracture. The summary included admitting and discharge diagnoses of a left hip fracture. The annual MDS dated 12/20/18 assessed Resident #61's fall history under section J1800 and revealed no falls occurred after being readmitted to the facility on 12/13/18. During an interview on 02/20/19 at 8:47 AM, the MDS Coordinator stated she completed Resident #61's annual MDS dated 12/20/18. After she reviewed the hospital discharge summary's admitting diagnoses which revealed a left hip fracture, she confirmed section J1800 was incorrect and should've been coded yes. A second interview on 02/20/19 at 10:29 AM, the MDS Coordinator revealed she modified section J1800 of the annual MDS assessment to show yes, a fall occurred upon reentry to the facility. When corrected she revealed section J1900 was available which she coded 1 fall occurred since readmission which identified a major injury due to a bone fracture. During an interview on 02/21/19 at 1:02 PM, the Director of Nursing (DON) explained the regional nurse reviewed and corrected the MDS assessments. All admissions were reviewed during the morning staff meetings and she didn't know why the fall was incorrectly coded by the MDS Coordinator. The DON revealed it was her expectation the MDS assessments would be coded correctly to reflect the resident.	F 641	There were no additional modifications required on these MDS assessments. Administrator/MDS Nurse Consultant provided education to MDS Coordinators on the importance of accurately coding the MDS assessment and comprehensively assessing in order to develop and implement a comprehensive care plan on 2/20/2019. A monitoring tool was developed to monitor MDS assessments for proper coding for section J1800. MDS coordinator or designee will utilize monitoring tool and will audit 10% of MDS assessments for coding accuracy for section J1800 weekly x 4 weeks, then monthly x 3 months. The results of these audits will determine the need for further monitoring. Audit results will be brought to QAPI meeting by the MDS nurses monthly x 4 months and will be reviewed and analyzed by the QAPI team.	
F 656	Develop/Implement Comprehensive Care Plan	F 656		3/5/19

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F 656 SS=D	Continued From page 2 CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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 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.	F 656		

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F 656	Continued From page 3 (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 observation, record review, and staff and physician interviews the facility failed to implement an identified care plan intervention for 1 of 1 resident reviewed for urinary catheter (Resident #80). The findings included: Resident #80 was readmitted to the facility on 01/10/19 with diagnoses which included renal insufficiency, multi-drug resistant organism (MDRO), and neurogenic bladder. A physician's order dated 01/10/19 indicated Resident #80 was to have a #20 French 30 cubic centimeter (cc) indwelling catheter, secured with a strap, placed in a privacy bag, and monitored every shift. The 5 day admission Minimum Data Set (MDS) assessment dated 01/17/19 indicated Resident #80 was cognitively intact, was total dependent for transfers, toileting, and personal hygiene, and required an indwelling catheter. A review of Resident #80's current care plan addressed a problem of urinary incontinence with a revision date of 12/28/18 which indicated Resident #80 had an indwelling urinary catheter related to neurogenic bladder, impaired activities of daily living (ADL) function, and mobility. The goal specified Resident #80 would have catheter managed appropriately as evidenced by not	F 656	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. Resident #80 did not experience any adverse effect/no harm related to a catheter strap not being in place. The care plan, already in place to address a urinary catheter has been implemented. The catheter strap was immediately placed on resident #80 to secure the catheter by hall nurse. The DON audited all residents with a urinary catheter to ensure a care plan to address a urinary catheter has been implemented and all resident with urinary catheters had the catheter secured with a leg strap on 2/20/2019. All were found to have a care plan implemented with leg strap in place. DON/SDC provided education to all licensed nursing staff and certified nursing assistants on catheter care to include leg straps being in place at all times on 2/20/2019. The education included ensuring care plan interventions are carried out. Any licensed nurse or	

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F 656	Continued From page 4 exhibiting signs of infection or urethral trauma. The approaches included staff were to provide catheter care per physician orders and to use catheter strap and assure enough slack was left in the catheter between urethral (duct to the bladder) meatus (opening into the body) and the catheter strap. An observation was conducted on 02/20/19 at 12:12 PM of Nurse Aide #1 providing urinary catheter care for Resident #80. Resident #80 was observed without a catheter strap in place to secure the catheter tubing to prevent tension on the urethral meatus and prevent kinking and dislodging of the catheter. Resident #80 did not have any observed signs of bleeding or trauma from the absence of a catheter strap. Nurse Aide #1 immediately obtained a catheter strap and secured the catheter tubing. On 02/20/19 at 1:07 PM a telephone interview was conducted with the physician who stated his expectation was that staff would have placed a catheter strap on Resident #80 to secure the indwelling catheter tubing to prevent tension and pulling on the catheter that could cause trauma to the urethral meatus. On 02/20/19 at 1:25 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident #80 would have had a catheter strap in place to secure the indwelling catheter tubing to prevent pulling and tension on the urethral meatus. On 02/20/19 at 1:35 PM an interview was conducted with the Administrator who stated her expectation was that Resident #80 would have had a catheter strap in place per clinical policy.	F 656	certified nursing assistant who is out on leave, vacation or PRN status will be educated upon their return to their assignment by the SDC/DON. A monitoring tool was developed to monitor catheter care and to ensure the residents with urinary catheters have their catheter secured with a leg strap. The monitoring tool is specific to ensuring that care plan interventions are carried out. DON/SDC/Designee will utilize monitoring tool and will audit all residents with a catheter weekly x 4 weeks, then monthly x 3 months. The results of these audits will determine the need for further monitoring. Audit results will be brought to QAPI meeting by the DON/SDC monthly x 4 months and will be reviewed and analyzed by the QAPI team.	

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F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff, and	F 690	Filing the plan of correction does not	3/5/19

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F 690	Continued From page 6 physician interviews the facility failed to secure indwelling urinary catheter tubing for 1 of 2 resident reviewed for urinary catheter (Resident #80). The findings included: Resident #80 was readmitted to the facility on 01/10/19 with diagnoses which included renal insufficiency, multi-drug resistant organism (MDRO), and neurogenic bladder. A physician's order dated 01/10/19 indicated Resident #80 was to have a #20 French 30 cubic centimeter (cc) indwelling catheter, secured with a strap, placed in a privacy bag, and monitored every shift. The 5 day admission Minimum Data Set (MDS) assessment dated 01/17/19 indicated Resident #80 was cognitively intact, was total dependent for transfers, toileting, and personal hygiene, and required an indwelling catheter. A review of Resident #80's current care plan addressed a problem of urinary incontinence with a revision date of 12/28/18 which indicated Resident #80 had an indwelling urinary catheter related to neurogenic bladder, impaired activities of daily living (ADL) function, and mobility. The goal specified Resident #80 would have catheter managed appropriately as evidenced by not exhibiting signs of infection or urethral trauma. The approaches included staff were to provide catheter care per physician orders and to use catheter strap and assure enough slack was left in the catheter between urethral (duct to the bladder) meatus (opening into the body) and the catheter strap.	F 690	constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. Resident #80 did not experience any adverse effect/no harm related to a catheter strap not being in place. The care plan, already in place to address a urinary catheter has been implemented. The catheter strap was immediately placed on resident #80 to secure the catheter by hall nurse. The DON audited all residents with a urinary catheter to ensure a care plan to address a urinary catheter has been implemented and all resident with urinary catheters had the catheter secured with a leg strap on 2/20/2019. All were found to have a care plan implemented with leg strap in place. DON/SDC provided education to all licensed nursing staff and certified nursing assistants on catheter care to include leg straps being in place at all times on 2/20/2019. Any licensed nurse or certified nursing assistant who is out on leave, vacation or PRN status will be educated upon their return to their assignment by the SDC/DON. A monitoring tool was developed to monitor catheter care and to ensure the residents with urinary catheters have their catheter secured with a leg strap.	

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F 690	Continued From page 7 An observation was conducted on 02/20/19 at 12:12 PM of Nurse Aide #1 providing urinary catheter care for Resident #80. Resident #80 was observed without a catheter strap in place to secure the catheter tubing to prevent tension on the urethral meatus and prevent kinking and dislodging of the catheter. Resident #80 did not have any observed signs of bleeding or trauma from the absence of a catheter strap. Nurse Aide #1 immediately obtained a catheter strap and secured the catheter tubing. An interview was conducted on 02/20/19 at 12:15 PM with Nurse Aide #1 who stated Resident #80 should have had a catheter strap in place to secure the indwelling urinary catheter. Nurse Aide #1 stated she did not know how long Resident #80 had been without a catheter strap. An interview was conducted 02/20/19 at 12:18 PM with Nurse #1 who stated Resident #80 should have had a catheter strap in place to secure the urinary catheter tubing to prevent tugging and tension on the catheter to prevent trauma to the urethral meatus. Nurse #1 verified that Nurse Aide #1 had applied a catheter strap to secure the indwelling catheter tubing for Resident #80 after the catheter strap was noted as absent. On 02/20/19 at 1:07 PM a telephone interview was conducted with the physician who stated his expectation was that staff would have placed a catheter strap on Resident #80 to secure the indwelling catheter tubing to prevent tension and pulling on the catheter that could cause trauma to the urethral meatus. On 02/20/19 at 1:25 PM an interview was	F 690	DON/SDC/Designee will utilize monitoring tool and will audit all residents with a catheter weekly x 4 weeks, then monthly x 3 months. The results of these audits will determine the need for further monitoring. Audit results will be brought to QAPI meeting by the DON/SDC monthly x 4 months and will be reviewed and analyzed by the QAPI team.	

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F 690	Continued From page 8 conducted with the Director of Nursing (DON) who stated her expectation was that Resident #80 would have had a catheter strap in place to secure the indwelling catheter tubing to prevent pulling and tension on the urethral meatus. The DON stated her expectation was that Nurse Aide #1 would have immediately placed a catheter strap to secure the indwelling catheter tubing in place. The DON stated her expectation and process was that Nurse Aide #1 would have informed Nurse #1 that Resident #80 did not have a catheter strap in place to secure the indwelling catheter tubing. On 02/20/19 at 1:35 PM an interview was conducted with the Administrator who stated her expectation was that Resident #80 would have had a catheter strap in place per clinical policy. The Administrator stated her expectation was that Nurse Aide #1 would have immediately placed a catheter strap on Resident #80 to secure the indwelling catheter tubing.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper	F 761		3/5/19

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F 761	Continued From page 9 temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to properly secure a medication on 1 of 2 medication carts reviewed for safe medication storage. Findings included: During an observation of 200 Hall on 02/20/19 at 8:42 AM, Nurse #2 removed a clear plastic bag from the medication cart and placed the plastic bag on top of the medication cart. Further observation indicated the outside of the clear plastic bag displayed a resident's name, medication name, dosage of medication, and date of 02/2020. The inside content of the clear plastic bag contained 9 individually sealed blister packages of Spiriva 18 micrograms (mcg) (medication used to increase airway to the lungs). At 8:43 AM, Nurse #2 left the medication cart with the bag of Spiriva medications still on top of the cart and Nurse #2 went to a resident's room to administer medications. Continuous observations from 8:43 AM to 8:53 AM, revealed Nurse #2 left a resident's room to go to the medication room and upon return to the medication cart, the	F 761	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. No resident experienced any adverse effect/no harm related to the Spiriva medications being left unattended on top of the medication cart. The medications were removed and secured in the medication cart immediately by the hall nurse. The DON audited all medication carts 2/20/2019. All were found to have drugs and biologicals stored in locked compartments to permit only authorized personnel access. DON/SDC provided education to nursing staff on storage of drugs to include all drugs and biologicals must be stored in	

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F 761	Continued From page 10 Spiriva was still sitting on top of the medication cart without Nurse #2 acknowledging the Spiriva. During the continuous observations from 8:43 AM to 8:53 AM, no residents or visitors were observed around or passing by the unattended medication cart with the Spiriva medication on top of the cart. During an interview on 02/20/19 at 8:53 AM, Nurse #2, stated that she made a mistake because the Spiriva should not have been left on top of the unattended medication cart. During an interview on 02/20/19 at 9:16 AM, the Director of Nursing (DON) stated her expectation was that the Spiriva should not have been left on top of the medication cart. She further stated that the medication should have been under the supervision of the nurse and kept locked in the medication cart when not in use. During an interview on 02/20/19 at 9:18 AM, the Administrator stated her expectation was the nurse should have followed the clinical policy regarding safe medication storage.	F 761	locked compartments to permit only authorized personnel access on 2/20/2019. All license nurses on LOA, vacation or PRN status will be educated by the SDC/DON upon return to their assignment. A monitoring tool was developed to drug storage. The audit includes whether medications on the medication cart are stored properly. DON/SDC/Designee will utilize monitoring tool and will audit all medication carts weekly on all 3 shifts x 4 weeks, then monthly on all 3 shifts x 3 months. The results of these audits will determine the need for further monitoring. Audit results will be brought to QAPI meeting by the DON/SDC monthly x 4 months and will be reviewed and analyzed by the QAPI team.	