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 06/23/2021

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

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F 000	INITIAL COMMENTS The survey team entered the facility on 06/22/21 to conduct a complaint investigation survey and exited on 06/23/21. One of three allegations was substantiated. Event ID # 6WUX11.	F 000		
F 550 SS=G	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without	F 550		7/5/21

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

Electronically Signed | 07/02/2021

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F 550	Continued From page 1 interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interviews the facility failed to provide incontinence care for 1 of 3 residents sampled for incontinence (Resident #2). The resident expressed feelings of being upset. The findings included: 1. Resident #2 was admitted to the facility on 04/06/21 with diagnosis that included renal insufficiency and Diabetes Mellitus. Review of Resident #2's quarterly Minimum Data Set (MDS) dated 04/13/21 revealed she was cognitively intact and required extensive assistance of two staff members for bed mobility and transfers. She was coded as being dependent on one staff member for assistance with toileting. Resident #2 was coded as being always incontinent of bladder and frequently incontinent of bowel. Review of Resident #2's care plan dated 12/12/19 and updated on 02/12/21 revealed a focus area for urinary incontinence. The care plan stated Resident #2 was incontinent of bowel and bladder and required fluid restrictions due to congestive heart failure and was at risk for urinary tract	F 550	F550 Residents affected: Resident #2 suffered no physical adverse effects related to the staffs alleged deficient practice. Resident #2 remains at the facility with no residual adverse effects. Other residents with the potential to be affected: All other incontinent residents in the facility have the potential to be affected. An audit was conducted on June 30, 2021, by Director of Nursing and/or Staff Development Coordinator Nurse by interviewing and/or direct observation to determine if any additional residents were affected by the alleged deficient practice. Residents that have been coded under incontinent from the point of care report was interviewed and/or observed to see if staff has been answering care light timely and care was being met. It was determined that no other residents were	

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F 550	Continued From page 2	F 550		

infections. Interventions included providing assistance to the bathroom, monitoring of fluid intake and frequent incontinence rounding.

On 06/22/21 at 1:45 PM an interview was conducted with Resident #2. During the interview she stated she had been waiting 30-45 minutes for incontinence care because she had urinated and had a bowel movement on herself. She stated the incontinence had soaked through her brief onto her denim pants and she was upset. The interview revealed she had turned on her call light and Nurse #3 came into the room to answer her call light. She stated she told Nurse #3 that she needed to be changed but the nurse did not give her time to explain the severity of her incontinence before leaving the room. The interview revealed Nurse #3 stated to her, "I'll let them know". During the interview with Resident #2, Patient Care Aide (PCA) #1 entered the room and asked the resident if she still needed to use the restroom because NA #2 was giving another resident a shower. Resident #2 told the PCA that she had a soiled brief and needed to be changed.

On 06/22/21 at 1:58 PM an observation was conducted of Nurse Aide #2 providing incontinence care for Resident #2. He stated he was working on another hall however NA #3 who was responsible for the hall was giving a resident a shower and had asked him to keep an eye on her hall. When NA #2 assisted Resident #2 to stand from her wheelchair her incontinence had soaked through her brief onto her pants requiring a complete change of her undergarments. NA #2 stated to Resident #2, "you had a mess". NA #2 cleaned the resident, providing a new brief and new pair of pants prior to assisting her back in her wheelchair and taking her to a facility activity.

adversely affected by the alleged deficient practice.

System Changes:

The facility policies related to incontinence care were reviewed by facility administration on June 29, 2021, and no updates were necessary.

NA #2, #3, and # 4 as well Nurse #3 were educated by Staff Development Coordinator on June 23, 2021, on the importance of answering call lights in a timely matter and expectation of staff being on the floor to ensure care is provided timely upon resident□s request.

PCA #1 was educated by Director of Nursing on June 24, 2021, on the importance of answering call lights, and if unable to fulfill resident□s request, that the Certified Nursing Assistant and/or nurse is notified of the resident needs/requests.

All staff will be educated regarding resident□s rights/exercising of resident rights and importance of answering call lights timely and providing timely incontinence care. This will be completed by the Staff Development Coordinator and/or designee by July 5, 2021. This education will include the following:

" The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside

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F 550	Continued From page 3 On 06/22/21 at 2:18 PM an interview was conducted with Nurse #3. She stated she was responsible for Resident #2's hall along with the isolation hall. The interview revealed NA #3 was assigned to the resident however was giving another resident a shower. She stated NA #4 was the second NA on the hall and she hadn't told her that she went on break. The interview revealed she saw Resident #2's call light on and went into the room to see what she needed. Resident #2 stated to her that she needed incontinence care and she told her she would tell the NAs. Nurse #3 stated she never had the chance to tell the NAs on the hall because she was called to another resident's room for a crisis situation requiring her attention. She stated when she came out of the other residents room Resident #2's light was off, and she thought the resident had already been assisted with incontinence care. On 06/22/21 at 2:28 PM an interview was conducted with PCA #1. She stated she was the only PCA hired in the building and was responsible for changing beds, passing meal trays and assisting residents with activities. The interview revealed she could not assist residents to the restroom. She stated she had answered Resident #2's light when it was originally on but knew NA #3 was giving another resident a shower and forgot to tell her Resident #2 needed assistance with incontinence care. On 06/22/21 at 2:42 PM an interview was conducted with NA #3. She stated she was assigned to Resident #2 on 06/22/21. The interview revealed nobody had told her Resident #2 needed to go to the restroom or incontinence care. She stated the last time she had provided	F 550	the facility. " A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. " The facility must protect and promote the rights of the resident. " The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. " The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. " Problems associated with incontinence and moisture, including skin breakdown " Preventing skin breakdown by providing timely incontinence care " Incontinent residents will be checked for incontinence every 2 hours at a minimum to determine the need for incontinence care. " The staff is to ensure someone is always present on the floor to meet resident□s requests. If non-clinical staff should respond to call lights and are not	

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F 550	Continued From page 4 incontinence care to Resident #2 was prior to the lunch meal at 12:00 PM. On 06/22/21 at 2:54 PM an interview was conducted with NA #4. During the interview she stated she was working on the hall with NA #3. She stated she was on break while NA #3 was in the shower room with another resident and was off of the hall for approximately 12 minutes. The interview revealed she thought she had told Nurse #3 she was going on her break however couldn't remember for sure. On 06/22/21 at 3:07 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated the NAs working on the hall were supposed to tell the Nurse if they go on break and report to the other NA on the hall to ensure someone is covering the hall. She stated she expected for someone to be on the hall at all times tending to the resident's care needs. On 06/22/21 at 3:25 PM an interview was conducted with the Administrator. During the interview she stated someone should be on the hall at all times monitoring and attending to the resident care needs. She stated she was going to write a concern form regarding the incident and investigate it.	F 550	able to meet the resident□s needs or requests, they are to inform the nurse and /or certified nursing assistant immediately. Any staff out on leave or prn status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired staff and contracted staff will be educated during orientation by the Staff Development Coordinator/designee. Monitoring: An audit tool was developed to monitor incontinent residents to ensure that timely incontinence care has been provided as necessary to maintain resident□s cleanliness and comfort and to determine if resident□s right regarding incontinence care were being followed, staff availability to meet resident□s request, and call lights being answer timely. Alert and oriented residents will be interviewed to ensure care needs are being met daily. The audit tool was initiated on June 28, 2021. The Director of Nursing, Staff Development Coordinator and /or designee will audit 5 incontinent residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x1 month. These audits will occur on random days, shifts, and weekends. The audit will consist of: " Has resident received incontinence care timely? " Was staff present on the floor?	

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F 550	Continued From page 5	F 550	" Call light answer timely? The need for further monitoring will be determined by the prior month of auditing. Quality Assurance Performance Improvement: The Director of Nursing and /or Staff Development Coordinator will bring results to the Quality Assurance Performance Improvement Committee for review and further recommendations. Completion date July 5, 2021.	
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and	F 600	F600	7/5/21

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F 600	Continued From page 6	F 600		

record review the facility neglected to provide incontinent care for 1 of 3 sampled residents (Resident #1) who required extensive assistance and who had requested incontinent care because he had soiled himself. Resident #1 stated he was embarrassed and angry after he had asked to be changed and was told the staff member did not have time resulting in him attempting to clean himself and experiencing a fall.

The findings included:

Resident #1 was admitted into the facility on 05/10/21 with diagnosis of renal insufficiency.

Review of Resident #1's admission Minimum Data Set (MDS) dated 5/17/21 revealed he was cognitively intact and required extensive assistance of two staff members for transfers. Resident #1 required extensive assistance of one staff member for dressing, toilet use and personal hygiene. The assessment revealed he was incontinent of bowel and bladder.

Resident #1's care plan dated 5/28/21 revealed a focus area for Activities of daily living (ADL). The focus area revealed the resident required assistance with ADL care due to limited mobility and incontinence. The goal was for the residents needs to be anticipated and met by staff as evidenced by a clean, neat appearance with no odors. Interventions included assist with transfers, provide assistance with toileting and incontinence care.

Review of an incident report dated 06/04/21 at 6:20 AM written by Nurse #2 revealed Resident #1 was observed on the floor. The resident stated he lost his balance leaning forward and slid onto

Residents affected:

Resident #1 did suffer adverse effects of soreness and pain from the fall which was related to the staffs alleged deficient practice. Resident #1 did experience emotional distress of embarrassment and anger after he had attempted to provide care to himself and sustained a fall. Resident #1 remains at the facility with no reported residual adverse effects.

Other residents with the potential to be affected:

All other residents that require extensive assistance in the facility have the potential to be affected. An audit was conducted on June 30, 2021, by Director of Nursing and/or Staff Development Coordinator Nurse by interviewing and/or direct observation to determine if any additional residents were affected by the alleged deficient practice. All residents that receive care were interview and/or responsible parties were interviewed to determine if any other residents were affected. It was determined that no other residents were adversely affected.

System Changes:

The facility policies related to abuse, neglect, misappropriation of resident property and exploitation were reviewed by facility administration on June 23, 2021, and no updates to the policy were necessary.

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F 600	Continued From page 7 the floor. No apparent injury was reported. The causative factor was described as being generalized weakness; poor core strength related to overall resident decline. The incident report revealed Resident #1 lacked the ability to sustain anatomical alignment Review of Resident #1's medical record revealed neurological check was initiated on 06/04/21 at 6:47 AM. The note revealed Resident #1 was observed on the floor with no complaints voiced from the resident. Resident #1 was released to the transportation company in stable condition for transport to dialysis following his fall. Review of Resident #1's physician orders dated 06/04/21 revealed an order to collect a clostridium difficile colitis specimen (a test to determine if there is inflammation of the colon caused by the bacteria clostridium difficile). The results from Resident #1's stool specimen revealed he had clostridium difficile organisms present in his bowel, but the toxin was not detected. The results stated it could be due to colonization, the resident may be a carrier, or the level of toxin was below the level of detection. An interview conducted with Resident #1 on 06/22/21 at 9:26 AM revealed on 06/04/21 Nurse Aide (NA) #1 was assisting him to get ready for dialysis when he began to experience diarrhea. He stated NA#1 assisted him to put his clothing on when he had a bowel movement on himself. He asked NA#1 to change his brief and clothing however she stated to him that she didn't have time to change him. He then told her he could't go to dialysis with feces on himself and to bring him supplies and he would try to clean himself up. The NA left the room to go get two wash cloths-	F 600	An allegation of neglect incident was reported to North Carolina Department of Health Service Division of Health and Service Regulation on June 23, 2021, and Investigation Report was submitted on June 24, 2021, which was substantiated. NA #1 employment ended with the facility on June 24, 2021. Nurse #1 agency contract ended with the facility on June 16, 2021, so therefore additional education was not provided to Nurse #1 or NA #1. Nurse #2, Interim Director of Nursing, and all staff including agency staff will be educated on Abuse, Neglect, Misappropriation of resident property and exploitation policy. This will be completed by the Staff Development Coordinator and/or designee by July 5, 2021. The education will consist of: • The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. • Allegations of abuse are to be reported to Administrator and/or Director of Nursing immediately. Any staff out on leave or prn status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired staff and contracted staff will be educated during orientation by the Staff	

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F 600	Continued From page 8 one wet and one dry which she handed to the resident, shut the door and left the room. He stated he was attempting to get the wash cloths from the bedside table when he leaned forward and fell onto his right side hitting his hip onto the floor and the right side of his head. The interview revealed he was sore and experienced pain but had no broken bones. He immediately began to yell for help from the staff and stated it was approximately 5 minutes before NA#1 and Nurse #1 entered the room. The interview revealed his call light was on the floor behind him and he couldn't reach it. He stated at 35 years old he felt embarrassed laying in bowel movement on the floor and being unable to care for himself. He also said he was angry at NA#1 for making him feel as if she didn't have time to help him or that the other residents were more important. On 06/22/21 at 9:56 AM an interview was conducted with Resident #1's Power of Attorney (POA). She stated the facility had contacted her on 06/04/21 regarding Resident #1's fall around 6:25 AM. The interview revealed she was confused because she knew the resident could not ambulate independently nor provide activities of daily living (ADL) care independently. The nurse on duty told her he was being prepared for dialysis when he had a bowel movement on himself and the NA told him she didn't have time to change him. When the resident attempted to clean himself, he experienced the fall due to loss of balance. She stated she immediately hung up with the nurse who notified her and called Resident #1 who stated he was still sitting in bowel movement and needed to be changed. She then stated she called the nurse back and asked her to go to his room and change him before he went to dialysis. She stated she could not	F 600	Development Coordinator/designee. Monitoring Tool: An audit tool was developed to ensure that resident requests for assistance with care are answered timely and care provided as requested. The audit will consist of the following questions: • Was care provided upon your request? • Did the staff assist you and/or your loved one with care requested? • Has the staff refused to assist you and /or your loved one with care and instructed you to care for yourself? The audit tool was initiated on June 30, 2021. The Director of Nursing, Staff Development Coordinator and /or designee will audit 3 alert and oriented residents and 3 responsible parties will be interviewed on behalf of the residents that are not alert and oriented weekly x 4 weeks, then biweekly x 4 weeks, then monthly x1 month. These audits will occur on random days, shifts, and weekends. The need for further monitoring will be determined by the prior month of auditing. Quality Assurance Performance Improvement: The Director of Nursing and /or Staff Development Coordinator will bring results	

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F 600	Continued From page 9 remember the name of the nurse whom she had spoken with. An interview conducted with NA #1 on 06/22/21 at 11:33 PM revealed she was working with Resident #1 during the third shift assignment on 06/04/21. She stated that morning she was getting the resident ready for dialysis and he was experiencing loose stools. She stated, "he was on his call light and I had to change him almost 8 times that night". The interview revealed she felt Resident #1 was constantly hitting his call light in need of assistance that morning. She stated, "I got frustrated with him when he said he was having another bowel movement". The interview revealed Resident #1 was dressed in his wheelchair for dialysis when he told NA #1, he had experienced a bowel movement and needed to be changed. She stated she told him that she didn ' t have time to change him again because he had to go to dialysis. The interview revealed NA #1 asked Resident #1 if he could clean himself if she set him up with a washcloth. She stated she gave Resident #1 a washcloth to clean himself with, left the room and shut the door behind her returning to her other assigned hall (Hall A) to assist other residents getting up. She stated when she was finished and returned to the hall around ten minutes later, she noticed his call light was not on and she heard Resident #1 yelling for help. When NA #1 entered Resident #1's room she observed him laying on his side in the floor in the middle of his room. She stated he was complaining of pain on his bottom and was laying in stool. NA #1 then left the room to get Nurse #1 to come assist her in getting him back to bed and cleaned up. She stated Nurse #1 no longer worked in the facility.	F 600	to the Quality Assurance Performance Improvement Committee for review and further recommendations. Completion date July 5, 2021.	

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F 600	Continued From page 10	F 600		

On 06/22/21 and 06/23/21 interviews were attempted with Nurse #1. Voicemails were left for Nurse #1 with no return phone call.

An interview conducted with Nurse #2 on 06/22/21 at 11:56 PM revealed she was working during third shift on 06/04/21 as the supervising nurse. She stated Nurse #1 had came up the hall and told her Resident #1 experienced a fall and asked for help completing an incident report. Nurse #2 stated she asked Nurse #1 how Resident #1 a fall and she had stated that the resident was cleaning himself up when he fell forward. Nurse #2 stated she knew Resident #1 was unable to complete ADL care independently, so she went immediately to his room to ask him why he was cleaning himself up. Resident #1 told Nurse #2 that he was sitting in his wheelchair when he had a bowel movement on himself and asked NA #1 to change him. He stated NA #1 told him she didn't have time to change him and he was trying to clean himself up before he went to dialysis because he didn't want to sit in feces. Nurse#2 stated she went out of his room and found NA #1 and to ask her to check him again to ensure he was clean prior to leaving and told her dialysis would not change him or clean him up. The interview revealed the dialysis transporter was in the facility at that time and she told him to wait 10 minutes so NA #1 could clean the resident prior to leaving the facility. Nurse #2 stated she told the Director of Nursing about the incident and he told her he didn't need her statement and if he did, he would call her. The interview revealed the DON had never contacted Nurse #2 regarding the incident. She stated Resident #1 seemed very upset and embarrassed over the situation.

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(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 600	Continued From page 11 On 06/22/21 at 11:18 AM an interview was conducted with the former Director of Nursing (DON). During the interview he stated he came into the facility on 06/04/21 to find the incident report in his box for Resident #1's fall. He stated he didn't recall talking to NA #1 that morning despite being in the building at 6:00 AM. The DON stated he went into the room to speak with Resident #1 and called his Responsible Party to inform her of the fall that had occurred. He stated he reviewed Resident #1's chart and saw how the nurses and NAs were transferring the resident to see if he was capable of being set up on his own to clean himself. The interview revealed Resident #1 was always laying flat in the bed and had lost his core strength and did not have the ability to sit up on his own. He stated Resident #1 was not appropriate to be alone by himself and required a one-person assistance with ADL. The DON stated he verbally spoke to the staff working with Resident #1 on 06/04/21 and informed them to not leave the resident alone and that he needed a one staff member assistance. He stated, "the resident looked young, so it made staff feel like he was able to complete task on his own". The interview revealed he had verbally conducted an in-service on the incident and didn't remember having written documentation of an in-service.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609		7/5/21

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F 609	Continued From page 12 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, resident, power of attorney and staff interviews the facility failed to implement their abuse and neglect policy in the area of reporting for resident neglect for 1 of 3 resident reviewed (Resident #1). The findings included: Review of Resident #1's admission Minimum Data Set (MDS) dated 5/17/21 revealed he was cognitively intact for decision making. He was coded as requiring extensive assistance of two staff members for transfers. Resident #1 required extensive assistance of one staff member for dressing, toilet use and personal hygiene. The assessment revealed he was incontinent of bowel	F 609	F609 Residents affected: An allegation of neglect incident was reported to North Carolina Department of Health Service Division of Health and Service Regulation upon notification to the Administrator by the State Surveyor on June 23, 2021. An investigation was initiated immediately by the Administrator. The findings of the investigation were submitted to NCDHSR on June 24, 2021. The allegation of neglect was substantiated, and the employee involved	

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F 609	Continued From page 13 and bladder. An interview conducted with Resident #1 on 06/22/21 at 9:26 AM revealed on 06/04/21 NA#1 was assisting him to get ready for dialysis when he began to experience diarrhea. He stated NA#1 assisted him to put his clothing on when he had a bowel movement on himself. He asked NA#1 to change his brief and clothing however she stated to him that she didn't have time to change him. He then told her he couldn't go to dialysis with feces on himself and to bring him supplies and he would try to clean himself up. The NA left the room to go get two washcloths - one wet and one dry which she handed to the resident, shut the door, and left the room. He stated he was attempting to get the washcloths from the bedside table when he leaned forward and fell onto his right side hitting his hip onto the floor and the right side of his head. He immediately began to yell for help from the staff and stated it was approximately 5 minutes before NA#1 and Nurse #1 entered the room. The interview revealed his call light was on the floor behind him and he couldn't reach it. An interview conducted with NA #1 on 06/22/21 at 11:33 PM revealed she was working with Resident #1 during the third shift assignment on 06/04/21. She stated that morning she was getting the resident ready for dialysis and he was experiencing loose stools. She stated, "he was on his call light and I had to change him almost 8 times that night". The interview revealed she felt Resident #1 was constantly hitting his call light in need of assistance that morning. She stated, "I got frustrated with him when he said he was having another bowel movement". The interview revealed Resident #1 was dressed in his	F 609	was terminated. Resident #1 did suffer from pain and emotional distress after sustaining a fall related to the deficient practice. Resident #1 remains at the facility with no reported residual adverse effects. Other residents with the potential to be affected: All residents in the facility have the potential to be affected by this deficient practice. An audit was conducted by the Administrator, the Director of Nursing (DON) and the Staff Development Coordinator (SDC) on July 2, 2021, by reviewing resident medical records and grievances for the past 30 days to determine if there were any additional allegations of abuse, neglect, misappropriation of resident property, exploitation and injuries of unknown source and if the facility reported any and all instances to the appropriate agencies per regulation. It was determined that no other residents were adversely affected. System Changes: The facility policies related to abuse, neglect, misappropriation of resident property and exploitation were reviewed by facility administration on June 23, 2021, and no updates to the policy were necessary. The facility will ensure that all alleged violations involving abuse, neglect,	

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F 609	Continued From page 14 wheelchair for dialysis when he told NA #1, he had experienced a bowel movement and needed to be changed. She stated she told him that she didn't have time to change him again because he had to go to dialysis. The interview revealed NA #1 asked Resident #1 if he could clean himself if she set him up with a washcloth. She stated she gave Resident #1 a washcloth to clean himself with, left the room and shut the door behind her returning to her other assigned hall (Hall A) to assist other residents getting up. She stated when she was finished and returned to the hall around ten minutes later, she noticed his call light was not on and she heard Resident #1 yelling for help. When NA #1 entered Resident #1's room she observed him lying on his side in the floor in the middle of his room. She stated he was complaining of pain on his bottom and was laying in stool. NA #1 then left the room to get Nurse #1 to come assist her in getting him back to bed and cleaned up. She stated Nurse #1 no longer worked in the facility. An interview conducted with Nurse #2 on 06/22/21 at 11:56 PM revealed she was working during third shift on 06/04/21 as the supervising nurse. She stated Nurse #1 had came up the hall and told her Resident #1 experienced a fall and asked for help completing an incident report. Nurse #2 stated she asked Nurse #1 how Resident #1 fell and she had stated that the resident was cleaning himself up when he fell forward. Nurse #2 stated she knew Resident #1 was unable to complete ADL care independently, so she went immediately to his room to ask him why he was cleaning himself up. Resident #1 told Nurse #2 that he was sitting in his wheelchair when he had a bowel movement on himself and asked NA #1 to change him. He stated NA #1 told	F 609	exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures. The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse, neglect or exploitation or mistreatment while the investigation is in progress. The facility must report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action is taken. Administrator and/or Director of Nursing will be responsible for completing and submitting 24 hour and 5-day investigation report. Nurse #1 agency contract ended with the facility on June 16, 2021, so therefore additional education was not provided to Nurse #1 or NA #1. Nurse #2 educated on June 18, 2021, and Interim Director of Nursing educated on	

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F 609	Continued From page 15 him she didn ' t have time to change him and he was trying to clean himself up before he went to dialysis because he didn't want to sit in feces. Nurse#2 stated she went out of his room and found NA #1 and to ask her to check him again to ensure he was clean prior to leaving and told her dialysis would not change him or clean him up. The interview revealed the dialysis transporter was in the facility at that time and she told him to wait 10 minutes so NA #1 could clean the resident prior to leaving the facility. Nurse #2 stated she told the Director of Nursing about the incident however he told her he didn't need her statement and if he did, he would call her. The interview revealed the DON had never contacted Nurse #2 regarding the incident. Review of the facility's 24-hour report and 5-day investigation reports revealed no initial 24-hour report, or 5-day investigation was filed regarding the incident with Resident #1 on 06/04/21. On 06/22/21 at 11:18 AM an interview was conducted with the former Director of Nursing (DON). During the interview he stated he came into the facility on 06/04/21 to find the incident report in his box for Resident #1's fall. He stated he reviewed Resident #1's chart and saw how the nurses and NAs were transferring the resident to see if he was capable of being set up on his own to clean himself. The interview revealed resident #1 was always lying flat in the bed and had lost his core strength and did not have the ability to sit up on his own. He stated Resident #1 was not appropriate to be alone by himself and required a one-person assistance with ADL. The DON stated he verbally spoke to the staff working with Resident #1 on 06/04/21 and informed them to not leave the resident alone and that he needed a	F 609	July 2, 2021, on Abuse, Neglect, Misappropriation of resident property and exploitation policy by the Staff Development Coordinator. The Director of Nursing and/or Staff Development Coordinator will educate all facility staff, including contracted staff on the policy, which includes definitions of abuse and reporting requirements for all facilty staff. The education will include the following: " All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency) in accordance with State law through established procedures. " All alleged violations are thoroughly investigated, and must prevent further potential abuse, neglect or exploitation or mistreatment while the investigation is in progress. " Must report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State	

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F 609	Continued From page 16 one staff member assistance. He stated, "the resident looked young, so it made staff feel like he was able to complete task on his own". The DON stated he did not complete a 24-hour report or conduct a 5-day investigation regarding the incident because he felt that it wasn't necessary.	F 609	law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action is taken. This will be completed by the Staff Development Coordinator and/or designee by July 5, 2021. Any staff out on leave or prn status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired staff and contracted staff will be educated during orientation by the Staff Development Coordinator/designee. Monitoring Tool: Director of Nursing and/or designee will review the nursing 24-hour reports, resident grievances, and progress notes daily 5 days a week for four weeks to to ensure compliance with the plan. Administrator and/or Director of Nursing will verify that 24-hour and 5-day reports were submitted timely to ensure compliance of reporting. Quality Assurance Performance Improvement: The Director of Nursing will bring results to the Quality Assurance Performance Improvement Committee for review and further recommendations.	

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F 609	Continued From page 17	F 609		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to use a total mechanical lift to transfer 1 of 3 residents (Resident #4) reviewed for accidents. Nurse Aide #5 used an assistive lift (sit to stand lift) and transferred Resident #4 without 2-staff assistance, resulting in a fall without injury. The findings included: Resident #4 was admitted to the facility on 12/8/15 with diagnoses that included ataxic cerebral palsy, repeated falls and abnormalities of gait and mobility. The Quarterly Minimum Data Set (MDS) assessment dated 5/7/21 indicated Resident #4 was cognitively intact and required extensive physical assistance with most activities of daily living including transfer in which he required 2-staff assistance. Resident #4's balance when moving from seated to standing position and during surface-to-surface transfer was not steady	F 689	Completion date July 5, 2021. F689 Residents affected: Resident #4 did suffer from mid-back pain from the staffs alleged deficient practice. Pain has been resolved. Resident #4 remains at the facility with no residual adverse effect. Other residents with the potential to be affected: All residents' that transfer with a lift have the potential to be affected. An audit was conducted on June 30, 2021, by Director of Nursing and/or Staff Development Coordinator Nurse by reviewing the resident's profile to ensure transfer status is appropriate for the residents. Audits consist of reviewing resident's profile report and validating transfer status was accurate per therapy evaluation. It was	7/5/21

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F 689	Continued From page 18	F 689		

and he was only able to stabilize with staff assistance. The MDS further indicated that Resident #4 had impairment to both lower extremities.

Resident #4's care plan last reviewed on 5/20/21 for standards of care required for Resident #4 revealed an intervention started on 1/8/21 for mechanical lift transfers: Total lift x 2 assist for transfers.

A review of an incident report entitled, "Summary of Investigation," dated 6/14/21 at 10:50 AM revealed Resident #4 was observed on floor. Nurse Aide (NA)#5 was present and indicated resident fell while being transferred with a sit to stand lift. The causative factor listed for the fall was that Resident #4 requested an alternate lift which was the sit to stand lift. The sit to stand lift was taken out of service for maintenance to check. Resident #4 complained of mid-back pain but denied hitting his head. The Director of Nursing (DON) discussed with Resident #4 to continue to use the total lift for transfers for his and staff's optimal safety.

An interview was conducted with Resident #4 on 6/22/21 at 11:10 AM. Resident #4 remembered having fallen on 6/14/21 morning before lunch time. Resident #4 stated after he got assisted with dressing in bed and was ready to be transferred out of bed and into his wheelchair, NA #5 used the sit to stand lift to transfer him into his wheelchair. Resident #4 could not remember if he had requested for NA #5 to use the sit to stand lift instead of the total lift but he added that he probably did and he did not want to get NA #5 in trouble. Resident #4 stated the sling on the sit to stand lift came loose and he slipped off the sling

determined that no other residents were adversely affected by the alleged deficient practice.

System Changes:

NA #5 was educated by the Director of Nursing on June 14, 2021. The education consisted of the following: Staff will follow the resident's profile and if resident requests any alternative to the transfer method on the resident profile, the employee must contact the licensed nurse. Competency was completed for Sit/Stand and Hoyer/Total Lift NA#5. Competency was conducted by Director of Nursing on June 14, 2021.

NA#5, Nurse #4, Rehabilitation Manager, therapy staff, and nursing staff including agency nursing staff will be educated on Transferring Policy as well resident's profile. Lifting and Transfer of Residents policy reviewed by administration staff on June 22, 2021, no revision necessary. The education will be conducted by Staff Development Coordinator and/or Director of Nursing. Education consisted of the following:

(1) Lifting and Transfer of Residents
(2) To follow resident's transfer profile.

Education is to be completed by July 5, 2021.

Resident's transfer status will be determined by the therapy dept upon resident's admission and documented in

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F 689	Continued From page 19 and fell to the floor. He remembered his whole back touched the floor when he fell, and he had some shoulder pain after the fall. Resident #4 stated he did not hit his head on the floor. Resident #4 confirmed that NA #5 was by herself when she transferred him using a sit to stand lift. The staff members got Resident #4 off the floor using a total lift and put him back into his wheelchair where he was assessed by Nurse #4. A phone interview with Nurse Aide (NA) #5 on 6/22/21 at 3:55 PM revealed that on 6/14/21, NA #5 had used the total lift to get Resident #4 off the bed and into a shower chair and then used the total lift again to transfer Resident #4 off the shower chair into his bed to help him get dressed. After getting Resident #4 dressed and ready to sit back in his wheelchair, Resident #4 insisted for NA #5 to use the sit to stand lift instead of the total lift. NA #5 stated she knew she was not supposed to use a sit to stand lift on Resident #4, but he begged her to use it instead of a total lift. NA #5 stated she placed the sling behind his back while hooking both sides to the sit to stand lift. She remembered locking the buckle that secured the sling on Resident #4. NA #5 also stated that she secured the leg straps around Resident #4' legs. NA #5 stated when she was getting ready to lower Resident #4 into his wheelchair, she suddenly heard a pop and then she saw Resident #4 fall to the floor. NA #5 was not sure what happened or what caused the pop but noticed that the sling was still on the sit to stand lift while Resident #4 had come off it and was on the floor. NA #5 further stated Resident #4 might have slid through the sling or the buckle on the sling might have come loose. NA #5 alerted Nurse #4 who helped get Resident #4 off the floor using a total lift. NA #5 confirmed she transferred Resident #4	F 689	the resident's profile to inform the staff of the appropriate way to transfer residents. Any staff out on leave or prn status will be educated prior to returning to their assignment by the Staff Development Coordinator/designee. Newly hired staff and contracted staff will be educated during orientation by the Staff Development Coordinator/designee. Monitoring Tool: An audit tool was developed to monitor transfer status to ensure residents are transferred appropriately according to the resident's profile. Audit tool consisted of the following: • Staff observed transferring resident to ensure resident's profile is being followed. The audit tool was initiated on June 30, 2021. The Director of Nursing, Staff Development Coordinator and /or designee will audit 5 residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x1 month. These audits will occur on random days, shifts, and weekends. The audit will include observations and interviews to ensure compliance. The need for further monitoring will be determined by the prior month of auditing. Quality Assurance Performance Improvement:	

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F 689	Continued From page 20 using the sit to stand lift by herself and she did not know why she did. NA #5 knew there was supposed to be another person present whenever she had to transfer Resident #4 due to his increased risk for falls. NA #5 reported this was not the first time Resident #4 had requested to be transferred using the sit to stand lift instead of the total lift. An interview with Nurse #4 on 6/22/21 at 10:21 AM revealed NA #5 came to her on 6/14/21 and notified her that Resident #4 had fallen. When Nurse #4 went to Resident #4's room, she observed him lying on the floor on his back. NA #5 told Nurse #4 that she had used the sit to stand lift to transfer Resident #4 instead of a total lift. Nurse #4 assisted NA #5 in getting Resident #4 back into his wheelchair using a total lift. Nurse #4 assessed Resident #4 for possible injuries and checked his vital signs which were normal. Resident #4 complained of shoulder pain, so Nurse #4 obtained an order to get an x-ray of his shoulders which turned out negative for any abnormal findings. An interview with the Director of Nursing (DON) on 6/22/21 at 11:30 AM revealed she found out about Resident #4's fall on 6/14/21 when both Resident #4 and NA #5 told her that he fell while he was being transferred using a sit to stand lift. Resident #4 had voiced multiple requests for NA #5 to just use a sit to stand lift instead of a total lift. When NA #5 started to lower Resident #4 into his wheelchair, she heard something pop and then Resident #4 came out of the sling. The DON stated they took the sit to stand lift out of service and had it checked by maintenance who could not find anything wrong with it or the sling that was used on Resident #4. The only thing the	F 689	The Director of Nursing and /or Staff Development Coordinator will bring results to the Quality Assurance Performance Improvement Committee for review and further recommendations. Completion date July 5, 2021.	

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 06/23/2021

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 689	Continued From page 21	F 689		

DON could figure out was that Resident #4 must have slipped out of the sling during the transfer using the sit to stand lift.

An interview with the Rehabilitation Manager (RM) on 6/22/21 at 11:48 AM revealed therapy had recommended for Resident #4 to use a total lift for transfers for safety due to his history of having cerebral palsy. The RM stated Resident #4 used to be able to use a sit to stand lift but he began to have issues with his core strength and was unable to bear at least 75% of his weight which was required in order to be able to use a sit to stand lift. He also remembered an episode when Resident #4 was working with physical therapy in January 2021 when they decided he needed a total lift for transfers. The RM stated he was familiar with Resident #4 and he did not have the shoulder strength to support himself in a sit to stand lift. The RM also stated all transfers using lifts should be performed by two staff members for safety especially with Resident #4.

An interview with the Administrator on 6/22/21 at 3:25 PM revealed she found out that Resident #4 had requested NA #5 to use a different lift when he fell on 6/14/21. The Administrator stated NA #5 should not have used a sit to stand lift and should have used a total lift which was on Resident #4's resident profile.