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 06/09/2022

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 and complaint investigation survey was conducted on 06/07/2022 through 06/09/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #PFRU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 06/07/2022 through 06/09/2022. Event ID# PFRU11 5 of the 5 complaint allegations were not substantiated . The following intakes were investigated: NC00189173, NC00186885, and NC00186035.	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 the Minimum Data Set (MDS) assessments for 2 of 35 resident assessments reviewed (Resident #25 and Resident # 87). Findings included: 1. Resident # 25 was admitted to the facility on 2/10/22 with diagnoses which included dementia, depression, and anxiety disorder.	F 641	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Residents affected: For Resident #25, the Minimum Data Set (MDS), dated 4/6/22, was modified by MDS Nurse #1 on 6/9/2022, to reflect that the resident did not have a diagnosis of	6/27/22

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

Electronically Signed | 06/29/2022

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F 641	Continued From page 1 A review of Resident #25's significant change Minimum Data Set (MDS), dated 4/06/22, revealed Resident #25 was moderately cognitive impaired. The MDS indicated Resident #25 had diagnoses which included, in part, anxiety disorder, depression, dementia and psychotic disorder. A review of Resident #25's Care Plan, last revised 4/25/22, revealed Resident #25 had been care planned for use of psychotropic medications and risk for adverse reactions/side effects related to psychiatric disorder and having a mental illness/intellectual disability. During an interview with the MDS Nurse Consultant on 6/09/22 at 10:00 a.m., the MDS Nurse Consultant stated the psychotic disorder was an error and was keyed in the system accidentally. Interview with the Administrator on 6/09/22 at 2:22 PM revealed she expected all MDS documentation be coded correctly. 2. Resident #87 was admitted to the facility on 4/01/22 with diagnosis that included diabetes, peripheral vascular disease, hypertension, chronic kidney disease and atrial fibrillation. Resident #87's discharge Minimum Data Set (MDS) dated 4/22/22 indicated Resident #87 was discharged to an acute hospital. Review of the medical record dated 4/22/22 indicated Resident #87 was discharged to the community with home health services not to an acute hospital.	F 641	psychotic disorder. Resident #25 did not suffer any adverse effects related to the alleged deficient practice. For Resident #87, the discharge MDS, dated 4/22/22 was modified by MDS Nurse #1 on 6/9/22, to reflect that the resident was discharged to an acute care setting. Resident #87 did not suffer any adverse effects related to the alleged deficient practice. All other residents with potential to be affected: On 6/23-6/27/22, an audit was completed by MDS Nurse #1 on all residents currently residing in the facility to verify that psychotic disorder diagnoses were accurately coded on the most recent MDS. No modifications were required and no additional residents suffered any adverse effects related to the alleged deficient practice. An audit was completed on 6/23/22 by Social Worker for all residents discharged within the last 30 days to verify that discharge location was accurately coded on the discharge MDS assessment. No modifications were required and no additional residents suffered any adverse effects related to the alleged deficient practice. Systemic changes: On 6/9/22, education was provided to MDS Nurse #1 and MDS Nurse #2 by the Administrator regarding the assessment process and the importance of coding the MDS accurately. Any newly hired MDS Nurse will be educated by the Regional Reimbursement Manager on this process during	

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F 641	Continued From page 2 During the interview on 6/09/22 at 11:50 AM, Minimum Data Set (MDS) nurse reviewed Resident #87 discharge MDS and confirmed it was inaccurately coded. The MDS nurse explained it was coded in error as Resident #87 was discharged to the community not to an acute hospital. During an interview on 6/09/22 at 2:19 PM with the Director of Nursing (DON) she acknowledged Resident #87 discharge MDS was inaccurately coded. She indicated that Resident #87 was discharged to the community to assisted living and the MDS dated 4/22/22 should have been coded to community not to acute hospital. Interview with the Administrator on 6/09/22 at 2:22 PM revealed she expected all MDS documentation be coded correctly.	F 641	orientation. Monitoring: An audit tool was developed to monitor the following: • MDS assessments for proper coding of discharge locations on the discharge MDS assessment. Audits will be completed for 100% of all discharged residents weekly for 8 weeks, then monthly for 2 months. • MDS assessments for proper coding of diagnoses. Audits will be completed on five MDS' weekly x 4 weeks, then biweekly x 2 months. Audits will be completed by a designee for MDS assessments completed by MDS Nurses. The results of these audits will determine the need for further monitoring. Results of the audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the MDS Nurses for review of sustained compliance with the plan of correction. Date of completion: 6/27/2022	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations	F 644		6/28/22

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F 644	Continued From page 3 from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to make a referral for re-evaluation after a change in mental health status for 1 of 2 residents (Resident #25) reviewed for Pre-Admission Screening and Resident Review. Findings included: A review of the North Carolina Department of Health and Human Services, Division of Medical Assistance, Preadmission Screening and Annual Resident Review (PASRR) application, dated 1/31/22, revealed Resident #25 had no mental health diagnoses included on the application. Resident #25 had been given the determination of a PASRR Level 1 with no expiration date. Resident # 25 was admitted to the facility on 2/10/22 with diagnoses which included dementia, depression, and anxiety disorder. A review of Resident #25's significant change Minimum Data Set (MDS), dated 4/06/22, revealed Resident #25 was moderately cognitive impaired and had not been considered by the State Level II PASRR process to have a serious mental illness. The MDS indicated Resident #25	F 644	The preparation and execution of the plan of correction does not constitute agreement by the provider that the alleged deficiency did in fact exist. This plan of correction is filed as evidence of the facilities desire to comply with the regulation and to provide high quality care. Residents affected: On 6/10/2022, the Administrator resubmitted a PASRR for Resident #25. On 6/22/2022, Administrator was notified by NC MUST that the level had not changed with the new PASRR application. Resident #25 suffered no adverse effects related to the alleged deficient practice. All other residents with potential to be affected: On 6/28/2022 the Administrator completed an audit of the residents readmitted to the facility within the last 30 days with a significant change in mental health status to determine if a referral for reevaluation of their PASRR level was completed. There were no additional residents who required resubmission of PASRR to NC MUST. No additional residents suffered any adverse effects related to the alleged	

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F 644	Continued From page 4 had diagnoses which included, in part, anxiety disorder, depression, dementia and psychotic disorder. A review of Resident #25's Care Plan, last revised 4/25/22, revealed Resident #25 had been care planned for use of psychotropic medications and risk for adverse reactions/side effects related to psychiatric disorder and having a mental illness/intellectual disability. During an interview with the Administrator on 6/09/22 at 9:45 a.m., the Administrator stated she was aware of the PASRR not being updated and the staff would update it immediately. The Administrator explained there had been a vacancy in the social work position, but PASARR would be corrected immediately. She expected PASRRs to be completed timely as per federal regulations. During an interview with the MDS Nurse Consultant on 6/09/22 at 10:00 a.m., the MDS Nurse Consultant stated the PASRR would be resubmitted for Resident #25 immediately. She explained it was overlooked.	F 644	deficient practice. Systematic changes: On 6/14/2022, the Social Worker was educated by the Administrator on proper process for resubmitting PASRR after a significant change in mental status. The education consisted of the process of verifying the PASRR application from the hospital upon readmission for proper diagnosis. Monitoring: An audit tool was developed to monitor for proper resubmission of PASRR for any resident with a significant change in mental health status. Administrator will complete audits weekly for 100% of all residents with a significant change in mental health status for four weeks, then 50% for 8 weeks. The results of these audits will determine the need for further monitoring. QAPI Findings of the audits will be brought by the Administrator to the Quality Assurance and Performance Improvement Committee monthly x 3 months for review and to ensure sustained compliance with the plan of correction. Date of completion: 6/28/2022	