STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/10/22 through 10/13/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #H7MV11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/10/22 through 10/13/22. Event ID# H7MV11. The following intakes were investigated NC00189636 and NC00192773. Six of the six complaint allegations were not substantiated.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		11/3/22

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

Electronically Signed | 11/03/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 1 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain privacy and confidentiality for 1 of 3 resident's medical records reviewed for privacy during medication administration. (Resident #5) The findings included: An observation was conducted of Nurse #2 on 10/12/22 at 9:40 AM. Nurse #2 walked away from the 100 Hall medication cart to go to another resident's room. Nurse # 2 left the computer screen open with Resident #5's information displayed. Staff and visitors passed by the cart while the resident's information was visible. Nurse #2 returned to the cart at 9:42 AM. An observation was conducted of Nurse #2 on 10/12/22 at 9:46 AM. Nurse #2 pulled Resident #5's medication and turned to walk in the room. Nurse #2 left Resident #5's information visible on the computer screen when she left the medication cart. Staff and visitors passed by the	F 583	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law. On 10/12/2022, immediate retraining was conducted by the Staff Development Coordinator (SDC) with Nurse #2 regarding protecting private health information by closing electronic medical record when left unattended in an area accessible to the public. Resident #5 was not adversely affected by the alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. A 100% audit was completed on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 2 cart while the resident's information was visible. An interview was conducted with Nurse #2 on 10/12/22 at 10:00 PM. Nurse #2 stated that should have placed the computer screen on the "step away" feature to prevent the resident's information from being on the screen while she was away. Nurse #2 stated that when she used this feature it required her to sign back in. An interview was conducted with the Director of Nursing and the Administrator on 10/12/22 at 11:53 AM. The Administrator stated that each computer had a tab in the right upper corner for the nurse to tap to prevent resident information from being viewed while the nurse was away from the cart. The Administrator stated that Nurse #2 should have used the privacy feature when walking away from the cart.	F 583	10/13/2022 by the SDC on all medication carts to ensure that all electronic medical records were closed, and no electronic medical record was left unattended, exposing resident□s personal and medical information in an area accessible to the public. No identified areas of concerns were identified during this audit. No additional residents were identified to have been affected by the alleged deficient practice. The Director of Nursing (DON) and Staff Development Coordinator (SDC) educated all licensed personnel on the policy regarding protecting private health information by closing electronic medical record when left unattended in an area accessible to the public. This education was completed by November 3rd, 2022. Any licensed personnel out on leave, vacation or PRN status will be educated prior to returning to their assignment by the SDC and/or DON. All newly hired licensed personnel or contracted licensed personnel will be educated on this policy during orientation by the SDC or DON. 100% of Electronic Medical Records on the Medication Carts will be monitored using an audit tool to ensure all electronic medical records are closed to protect private health information when left unattended in an area accessible to the public. The audit will contain the following: " Is the computer closed when left unattended? To ensure continued compliance, audits	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 3	F 583	will be conducted by the SDC, DON, or their designee for all medication cart computers weekly on alternating shifts including weekends x 4 weeks, then monthly x 2 months. The results of these audits will determine the need for further monitoring. All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON, for review and to ensure continued compliance with the plan of correction.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview, staff and physician interviews, the facility failed to obtain a physician order for supplemental oxygen for 1 of 2 residents reviewed for oxygen (Resident #24). Findings included: Resident #24 admitted to the facility on 3/01/22 with diagnoses which included obstructive sleep	F 695	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law.	11/3/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 4 apnea and respiratory failure. Record review of the Minimum Data Set (MDS) Quarterly Assessment dated 7/22/22 revealed Resident #24 was cognitively intact and was not coded for oxygen use. During observations on 10/12/22 at 3:34 pm and 10/13/22 at 9:10 am Resident #24 was observed with 2 liters (L) of oxygen via nasal canula (NC) in use. Record review of the active physician orders revealed no order for supplemental oxygen. During an interview on 10/13/22 at 9:10 am Resident #24 revealed he started using the oxygen a few days ago, but he was not sure why. Resident #24 stated he felt better with the oxygen in place. During an interview on 10/13/22 at 9:15 am Nurse #1 revealed Resident #24 had the oxygen in place for the two days she was assigned to his care. She stated Resident #24 had a history of respiratory distress and that may be the reason the oxygen was in use, but she was not certain. Nurse #1 stated she was not sure if it required a physician order. An attempt to interview Nurse #2, who was assigned to Resident #24 on 10/11/22 on the overnight shift, was unsuccessful. During an interview on 10/13/22 at 12:13 pm the Director of Nursing (DON) revealed a physician order was required for supplemental oxygen. She stated the nurse on the unit was required to enter a physician order for supplemental oxygen	F 695	On 10/13/2022, Director of Nursing (DON) contacted the residents□ physician and obtained a physicians□ order for Resident #24 for oxygen at 2 liters per minute via nasal cannula to be used continuously. Resident #24 was not adversely affected by the alleged deficient practice. On 10/13/2022, the Director of Nursing (DON) and the RN Supervisor audited 100% of all residents in the facility that were using oxygen to ensure that there was a physicians□ order for its use. During this audit all residents using oxygen had a physician□s order for its use. No other resident was adversely affected by the alleged deficient practice. All licensed nursing staff will be educated by the DON or RN Supervisor by 11/3/2022 on the following: " A physician□s order must be obtained to administer oxygen to any resident. Any licensed nursing staff out on leave, vacation or PRN status will be educated by the Staff Development Coordinator (SDC) or designee prior to returning to duty. All newly hired licensed nursing staff will be educated by the SDC during orientation. An audit tool was developed which included the following: " Is there a physician□s order for the use of oxygen? The RN Supervisor will audit 50% of residents that are using oxygen weekly for four weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 10/13/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 5 for Resident #24. The DON was not aware Resident #24 was on supplemental oxygen. During an interview on 10/13/22 at 12:40 the Medical Director revealed Resident #24's supplemental oxygen required an order and could be obtained from the on-call provider or himself when needed.	F 695	audits will determine the need for further monitoring. All results will be brought to our monthly Quality Assurance and Performance Improvement Committee meeting monthly x 3 months by the RN Supervisor. All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON, for review and to ensure continued compliance with the plan of correction.	