STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345337	A. BUILDING _____ B. WING _____	C 09/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - ALAMANCE, INC	215 COLLEGE STREET GRAHAM, NC 27253

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 09/18/23 through 09/19/23. Event ID# SUQ911. The following intakes were investigated: NC00207335, NC00207166, and NC00206294. 1 of the 5 complaint allegations resulted in a deficiency.	F 000		
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 and staff and Nurse Practitioner interviews, the facility failed to provide incontinent care safely for 1 of 3 residents reviewed for accidents (Resident #1). During incontinent care provided by Nurse Aide (NA) #1, Resident #1 rolled off the bed and landed on her knees with no injuries. The findings included: Resident #1 was admitted to the facility on 07/07/21 with multiple diagnoses which included vascular dementia with behavioral disturbance and difficulty in walking. A physician order dated 08/19/23 indicated Resident #1 was prescribed Apixaban (a	F 689	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of this plan 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 the state and federal law. Resident affected by the alleged deficient practice: On 9/1/2023, the care plan and resident profile was reviewed and updated for Resident # 1 to include a two-person assistance for care and bed mobility. Certified Nursing Aide # 1 was educated by the Administrator on 09/01/2023. This education included the following:	10/2/23

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

Electronically Signed | 09/29/2023

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.

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F 689	Continued From page 1 medication to prevent blood clots) 2.5 milligrams twice a day for atrial fibrillation. The quarterly Minimum Data Set (MDS) assessment dated 08/22/23 indicated Resident #1 had moderate cognitive impairment, required extensive assistance of one with bed mobility, toilet use, and personal hygiene. Resident #1 was coded as not having behavioral symptoms or refusal of care. The MDS indicated the resident was always incontinent of bowel and bladder. The MDS further indicated the resident had a fall in the last month, the last 2 to 6 months, and had a fracture related to a fall in the last 6 months. Review of NA #1's telephone interview transcript dated 09/01/23 revealed NA #1 asked Resident #1 to roll over, and when she started to roll, Resident #1 did not stop rolling. NA #1 was on the right side of the bottom of the bed. Resident #1 was turning to the left side of the bed. As NA #1 was walking to the left side, Resident #1 was still in the bed, but the resident kept rolling. She grabbed the resident's brief and pad and held onto her to keep her from falling out of the bed. Resident #1 slowly lowered herself to the floor with NA #1's assistance. Resident #1 was on her knees facing the bed with her chest on the bed. NA #1 stood behind her while she assisted the resident onto her back with her head resting on the wall between the bed and nightstand. During a phone interview on 09/18/23 at 1:05 PM, NA #1 reported she was in the resident's room providing care on 09/01/23. During the interview, NA #1 described the following, Resident #1 was in a good mood and was not exhibiting negative behaviors. Resident #1 needed to be changed due to having a urinary incontinence episode. NA	F 689	• Resident #1 will require 2-person assist for ADL (Activities of daily living) and care. • Resident #1 will require 2-person assist for bed mobility. • Ensure the residents is a safe position prior to performing incontinent care Resident # 1 did not suffer any adverse effect from the alleged deficient practice and remains in the facility. Residents with potential to be affected: All residents performing bed mobility during incontinent care have the potential to be affected by the alleged deficient practice. On 9/28/2023, Administrative nursing staff reviewed all falls out of bed for the last 30 days to determine if any other residents were affected by the alleged deficient practice. There were no other residents identified. System Changes An inservice was initiated by the Assistant Director of Nursing on 9/27/2023 for all direct care staff. This education included the following: • Ensure the resident is in a safe position prior to performing bed mobility during incontinent care • Obtain assistance from a second staff member if need to safely position a resident in bed prior to performing incontinent care All newly hired direct care staff will be educated by the Assistant Director of Nursing (ADON) or designee during orientation. Any direct care staff out on leave or prn status will be educated by the Assistant Director of Nursing or designee upon returning to duty.	

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F 689	Continued From page 2 #1 had the bed raised up to her waist height when she had just finished cleaning the resident and had put a clean brief on her while the resident was lying on her right side. While NA #1 was walking to the left side of the resident's bed, she instructed Resident #1 to roll over to the other side. Resident #1 rolled over but did not stop. She stated she lunged over the bed and held onto the resident's waist. She assisted Resident #1 onto her knees. Resident #1 was resting on her knees with her body leaning against the bed. She assisted Resident #1 onto her back because she could not stay on her knees. She called for the nurse to help assist Resident #1 back into her bed. Resident #1 did not hit her head or complain of pain. She indicated she had been in-serviced on how to properly turn and reposition the residents at the facility. A nurse progress note completed by Nurse #1 dated 09/01/23 indicated she was called into Resident #1's room by NA #1. Resident #1 was noted to be on her back on the floor beside the bed. NA #1 stated she was changing the resident and her rolling over. The resident kept on rolling out of bed onto the floor. Resident #1 was assisted back to bed. The on-call Nurse Practitioner was notified and was instructed to continue to monitor. Resident #1's Responsible Party was also notified. The investigation report of the incident dated 09/01/23 completed by Nurse #1 indicated she was called into Resident #1's room by NA #1. Resident #1 was noted to be on her back on the floor beside her bed. NA #1 stated she was changing the resident and had her roll over. Resident #1 kept on rolling out of bed onto the floor. Resident #1 was assisted back to bed by	F 689	Monitoring: An audit was developed to monitor for compliance with the plan of correction. The audit includes the following: • Was the resident properly positioned in bed prior to performing incontinent care Administrative nurses will audit 5 residents per week x 4 weeks, including random shifts and weekends, then will audit 5 residents biweekly x 4 weeks, then 5 residents monthly x 1 month to ensure continued compliance with the plan of correction. QAPI (Quality Assurance and Performance Improvement): The results of these audits will be brought to the QAPI committee monthly x 3 months by the Assistant Director of Nursing for review and further recommendations to ensure compliance with the plan of correction. Completion date: October 2,2023	

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F 689	Continued From page 3	F 689		

Nurse #1 and NA #1. The report indicated behaviors and medication were factors that may have contributed to the event.

Review of Nurse #1's telephone interview transcript dated 09/01/23 she was notified by NA #1 at approximately 6:15 AM she needed assistance in Resident #1's room due to an assisted fall. She went into the room and found Resident #1 on the floor. NA #1 and Nurse #1 assisted the resident back into bed.

During a phone interview on 09/19/23 at 9:38 AM, Nurse #1 stated she was walking down the hallway when NA #1 came to her and informed her Resident #1 was on the floor. When she went into the room, she noticed Resident #1 was lying flat on her back with her head against the wall. She stated NA #1 told her she was on the other side of the bed when Resident #1 rolled off the bed. NA #1 told her Resident #1 was on her knees and because she could not stay in the position, NA #1 assisted her to her back. She assessed Resident #1 and Resident #1 did not complain of any pain. There were no injuries noted and she assisted Resident #1 back to bed with the help of NA #1.

A progress note dated 09/01/23 completed by the Nurse Practitioner indicated Resident #1 was seen due to a witnessed fall. Per report, NA #1 turned the resident to provide peri-care and the resident slid off the bed onto her knees and then leaned against the wall. NA #1 stated the resident did not hit her head. There were no injuries observed by nursing staff at the time of the fall. The resident later complained of headache and neuro checks were initiated. On exam, the resident stated she did hit her head and pointed

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F 689	Continued From page 4	F 689		

to her forehead. There was no swelling or bruising noted to her face or changes to her range of motion. Further, there was no bruising or wounds on her body. The resident's vital signs were stable. The resident was on a blood thinning medication. Resident #1 was sent to the ER for an assessment due to the fall, headache, and being on blood thinning medication.

During an interview with the Nurse Practitioner on 09/19/23 at 9:47 AM, she stated she was informed by staff Resident #1 rolled out of bed while NA #1 was providing personal care. NA #1 stated the resident did not hit her head; however, when she spoke with Resident #1, she informed her she did hit her head. She stated the resident was sent to the hospital because of Resident #1's Responsible Party's request and the resident complaining of a headache. Resident #1 returned from the hospital the same day because there were no injuries. She stated Resident #1 has schizophrenia and dementia, which caused resident to have behaviors. She stated the cause of the fall was related to the resident's behavior.

Review of the Emergency Room Physician Note dated 09/01/23 revealed Resident #1 presented to the emergency room after sustaining a fall. She was reportedly bedbound and while she was being changed, she rolled out of bed. There was no loss of consciousness or head strike. Resident #1 reported to the triage nurse that she had a headache, but denied this complaint to the physician, instead stating that her back was hurting since her fall. The resident reported no other medical complaints. The note indicated even though there was an actively low mechanism for injury she was admitted for observation due to her age and use of

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F 689	Continued From page 5	F 689		

anticoagulants (medications used to prevent blood clots). Computerized Tomography (CT) scans were performed on her head, chest, abdomen, pelvis, and spine. There were no acute findings of injury. She was discharged on 09/01/23 because she was in stable condition throughout her emergency room stay and there were no acute traumatic injuries noted on the imaging.

Resident #1's care plan was updated on 09/01/23 after her return from the hospital to reflect a new intervention of Resident #1 was to have 2-person assistance with all Activities of Daily Living (ADL) care, bed mobility, and repositioning.

Resident #1's care plan which was last reviewed on 09/07/23 indicated Resident #1 had a focus area of behavioral symptom in which resident's actions characterized by ineffective coping, verbal/physical aggression or combativeness related to cognition, impairment, anger, inability to perform tasks, and sundown. The goal included staff would ensure safety for resident(s) and staff. Interventions included approaching resident slowly when entering room; be cognizant of not invading resident's personal space; and help resident cope using past successful coping mechanisms.

During an interview with the Director of Nursing (DON) on 09/19/23 at 3:01 PM, indicated NA #1 was aware of how to turn and reposition residents. She stated when NA #1 was providing care to Resident #1, she rolled and fell from bed to floor due to the resident's behaviors. She stated NA #1 was re-educated on safe turning and repositioning while providing care to residents. Resident #1's care plan was also

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F 689	Continued From page 6 changed to reflect the resident needed 2 staff members for personal care. The Administrator was interviewed on 09/19/23 at 3:39 PM. She stated they had completed an investigation on how the resident fell from the bed to the floor, and they determined that the resident rolled out of bed due to the resident rolling over prematurely. The resident was sent to the hospital out of precaution and per the resident's Responsible Party's request. The resident returned the same day because there were no injuries. NA #1 was educated on ensuring she was standing in front of the resident when the residents were being rolled.	F 689		