| 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 01/25/2024 |

| 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 |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation survey was conducted on 1/22/24 through 1/25/24. The facility was found in compliance with the requirement CFR 483.73,Emergency Preparedness. Event ID#O7UO11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted on 1/22/24 through 1/25/24. Event ID#O7UO11.<br><br>The following intakes were investigated, NC00208461, NC00211903, NC00204349, and NC00210907.<br><br>Sixteen of the Sixteen complaint allegations did not result in a deficiency. | F 000 | | |
| F 638 SS=B | Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)<br><br>§483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to complete the Minimum Data Set (MDS) quarterly assessments at a minimum of every 3 months for 1 of 3 residents reviewed for MDS records over 120 days (Resident #65).<br><br>The findings included:<br><br>Resident #65 was admitted to the facility on | F 638 | Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality care.<br>F638<br>Affected Residents<br>Resident #65 did not suffer any adverse | 2/9/24 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/07/2024

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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8/16/23.

Resident #65's Minimum Data Set (MDS) quarterly assessment with an Assessment Reference Date (ARD), (the last day of the 7-day lookback period) of 8/19/23 was observed in the electronic medical record as completed on 10/24/23.

Resident #65's MDS quarterly assessment with an ARD of 11/10/23 was observed in the electronic medical record as completed on 1/18/24.

A telephone interview was conducted on 1/25/24 at 8:18 am with the MDS Nurse #1 who revealed the MDS assessments were generally completed within a 14-day period. The MDS Nurse #1 stated there was a report that MDS ran sometimes which would list missed assessments that need to be completed and that would trigger them to complete those assessments that were late or missed. MDS Nurse #1 was unable to state why the MDS quarterly assessments were completed late for Resident #65.

An interview was conducted on 1/25/24 at 9:24 am with the MDS Nurse #2 who confirmed Resident #65's MDS quarterly assessment completion dates for the 8/19/23 and 11/10/23 assessments were late based on the date and signatures on the assessments. The MDS Nurse #2 stated the quarterly assessments should have been completed within 14 days of the ARD. She stated she manually entered the dates for the assessments in the electronic medical record and then she would run the assessment report which would show when the assessments were due. The MDS Nurse #2 stated she must have just

**F 638**

effect from the alleged deficient practice. The MDS was completed and transmitted on 01/18/2024 by MDS Nurse #1.
Residents with the potential to be affected Minimum Data Set (MDS) Nurse # 1 & MDS Nurse #2 audited 100% of all resident MDS assessments to ensure all in house residents had a quarterly assessment scheduled. This audit was completed on 01/30/2024. No resident suffered any adverse effect from the alleged deficient practice.
Systemic Changes
The Administrator educated MDS Nurse #1 and MDS Nurse # 2 regarding the requirement of completing MDS assessments quarterly. This education was completed on 2-5-2024. This education is provided to any newly hired MDS nurse by the Regional Reimbursement Manager during the orientation process.
Monitoring
An audit tool was developed to monitor the completion of quarterly MDS assessments. MDS Nurse #1 will audit MDS assessments completed by MDS Nurse #2 and MDS Nurse #2 will audit MDS assessments completed by MDS Nurse #1. Audits will be completed by the MDS nurses for 25% of all MDS assessments weekly x 4 weeks, then 25% monthly for 2 months. 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 meeting monthly by the MDS Coordinators for review and further

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| F 638 | Continued From page 2<br>missed completing Resident #65's quarterly assessments; she further stated sometimes things were just missed.<br><br>During an interview on 1/25/24 at 9:43 am with the Director of Nursing (DON) stated she was not certain of the time frame the assessments were to be completed. The DON revealed she did not normally monitor the MDS assessment for completion and she was unable to state how the MDS assessments for Resident #65 was completed late.<br><br>An interview with the Administrator was conducted on 1/25/24 at 9:48 am who revealed the MDS Nurses were responsible for completing the MDS assessments on time. | F 638 | recommendations.<br>Completion Date:02/09/2024. | |
| F 640 SS=B | Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4)<br><br>§483.20(f) Automated data processing requirement-<br>§483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility:<br>(i) Admission assessment.<br>(ii) Annual assessment updates.<br>(iii) Significant change in status assessments.<br>(iv) Quarterly review assessments.<br>(v) A subset of items upon a resident's transfer, reentry, discharge, and death.<br>(vi) Background (face-sheet) information, if there is no admission assessment.<br><br>§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the | F 640 | | 2/9/24 |

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CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete the Minimum Data Set (MDS) assessments for 2 of 3 residents reviewed for discharge (Resident #67 and Resident #5).

Findings included:

1.Resident #67 was admitted to the facility on

This plan of correction constitutes our written allegation of compliance for the deficiency 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 the state and federal law.

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8/31/23.

Review of Resident #67's medical record revealed the resident was discharged home on 9/12/23. There was no documentation in Resident #67's medical record that the discharge MDS assessment had been completed.

During an interview with the MDS Nurse #2 on 1/25/24 at 9:24 AM she indicated Resident #67 should have had a discharge MDS completed. MDS Nurse #2 was unable to state why the discharge MDS assessment had not been completed for Resident #67.

During an interview on 1/25/24 at 9:43 AM with the Director of Nursing (DON) stated she was not certain of the time frame the assessments were to be completed. The DON revealed she did not normally monitor the MDS assessment for completion and she was unable to state how the MDS assessment for Resident #67 was not completed.

An interview with the Administrator was conducted on 1/25/24 at 9:48 am who revealed the MDS Nurses were responsible for completing the MDS assessments.

2. Resident #5 was admitted to the facility on 8/28/23.

Review of Resident # 5's discharge MDS assessment dated 9/26/23 was observed in the electronic medical record as "completed" but not transmitted until 1/18/23.

During an interview on 1/25/24 at 9:43 am with the Director of Nursing (DON) stated she was not

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Residents affected
The Minimum Data Set (MDS) data was transmitted on 01/18/2024 for resident #5 and 01/25/2024 on resident #67 by MDS Nurse #1. Resident #5 and Resident #67 did not suffer any adverse effects related to the alleged deficient practice.

Other residents with the potential to be affected:

All residents with MDS assessments due in the last 45 days were audited by MDS Nurse #1 and MDS Nurse #2. All additional MDS Assessments requiring modification and/or submission were transmitted on 02/02/2024 by MDS Nurse #1. No other resident was adversely affected by the alleged deficient practice. Completion date 02/02/2024.

Systemic Changes
MDS Nurse #1 and MDS Nurse #2 were educated by the Administrator on 01/25/2024 on transmitting resident assessments within 14 days of completion and completing discharge assessments. Any newly hired MDS nurse is educated on this process during orientation by the Regional Reimbursement Manager.
Monitoring
10 MDS assessments will be audited for transmission within 14 days of completion weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. MDS Nurse #1 will audit MDS Nurse #2 and MDS Nurse #2 will audit MDS Nurse #1. The need for further monitoring will be determined by the prior month of auditing.

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| F 640 | Continued From page 5<br>certain of the time frame the assessments were to be transmitted. The DON revealed she did not normally monitor the MDS assessment for completion or transmission and she was unable to state how the MDS assessment for Resident #5 was transmitted late.<br><br>An interview with the Administrator was conducted on 1/25/24 at 9:48 am who revealed the MDS Nurses were responsible for completing and transmitting the MDS assessments. | F 640 | Quality Assurance Performance Improvement<br>The MDS Coordinator will bring results to the Quality Assurance and Performance Improvement Committee for review and further recommendations monthly x 3 months.<br>Completion date 02/09/2024. | |