STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 onsite recertification survey was completed 4/18/2024. The facility was not in compliance with the requirement at CFR 483.73, Emergency Preparedness. Event ID # INR311.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 §403.748, §416.54, §418.113, §441.184, §460.84, §482.15, §483.73, §483.475, §484.102, §485.68, §485.542, §485.625, §485.727, §485.920, §486.360, §491.12 The [facility, except for Transplant Programs] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility, except for Transplant Programs] must establish and maintain a [comprehensive] emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: * (Unless otherwise indicated, the general use of the terms "facility" or "facilities" in this Appendix refers to all provider and suppliers addressed in this appendix. This is a generic moniker used in lieu of the specific provider or supplier noted in the regulations. For varying requirements, the specific regulation for that provider/supplier will be noted as well.) *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this	E 001		5/8/24

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

Electronically Signed | 05/10/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 001	Continued From page 1 section, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. The emergency preparedness program must include, but not be limited to, the following elements: This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to establish and maintain a comprehensive Emergency Preparedness (EP) plan. The facility failed to review and update the current staff information, maintain an updated emergency food supply list, and failed to document needed areas of improvement on the Elopement Drill Evaluation following the full-scale community-based exercise in the EP. The findings included: A review of the facility's supplied Emergency Preparedness plan revealed the Administrator had reviewed the material on January 8, 2024. The following areas were not updated or revised: A. The facility's food Emergency Supply list was last updated on 4/21/2021. The Emergency Food supply list revealed the following items: 1 case of soy milk, 8 containers of powdered milk (5 gallons each), 4 cans of chicken soup (50 ounces each), 12 cans tomato soup (50 ounces each), 4 cans of vegetable soup (50 ounces each), 2 cases of sliced peaches, 2 cases of fruit cocktail,	E 001	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. Residents affected: On 05/02/2024, the Administrator updated the Emergency Preparedness Plan with the menu of the current emergency food supply. The Dietary Manager ordered and obtained all supplies on 05/07/2024. On 05/03/2024, the Administrator updated the Emergency Preparedness Plan with the current staff list, including names and telephone numbers. On 05/06/2024, the Administrator completed an After-Action Form for the community-based elopement drill. The items included the following: Notification of Police, Notification of Physician, Notification of Family and/or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 001	Continued From page 2 3 cases of chocolate pudding, 6 cans of tuna (66.5 ounces each), 6 cases of black-eyed peas, 4 cases of baked beans, 5 cases of pinto beans, 2 packages of mashed potato pearls, 1 box of cornbread, 2 packages of Jello, 1 oatmeal canister, 1 canister of instant grits, 2 cases of foam containers (9x9), and 2 cases of disposable cutlery kits. The emergency food supply should contain enough food to last three days for both the residents on the Skilled Nursing and Assisted Living units (127 bed capacity), facility staff, visitors, etc. in the event of an emergency and sheltering in place was required. B. The facility's staff contact information was last updated on 6/18/2021, staff who were hired after 6/18/2021 were not included in the staff contact information. C. The facility's full-scale community-based elopement drill dated 4/21/2023 revealed 19 facility staff participated in locating a missing resident. Documentation revealed the exercise lasted 5 minutes, the Administrator was notified, and the staff performance was excellent. Further review of the drill revealed staff had not contacted the police, the resident was not examined when located, the physician was not notified when the resident went missing or was discovered, the family and/or representative was not notified when the resident went missing or was discovered, an incident/event report was not completed, and there was no notation included in the medical record. An interview was conducted on 4/16/2024 at 3:00 pm with the Dietary Manager (DM). The DM reported Emergency Supplies were kept in a dry storage room and she checked inventory	E 001	Representative, Resident examination when found and incident/event report completion and notation in Medical Record of resident. Residents with potential to be affected: All community-based drills from 1/1/2024 to present were audited for completion of an after-action form by the Administrator to ensure all necessary items were completed. There were no additional issues identified on these audits. This was completed on 05/06/2024. No residents suffered any adverse effects related to the alleged deficient practice. Systemic changes: The Administrator was educated by the Corporate Compliance Manager on 05/08/2024, regarding the Emergency Preparedness Program and Plan including the following: • An updated staff contact list must be maintained • An updated menu and emergency food supply must be maintained • Areas of improvement must be identified, documented and corrected after any table-top or full-scale emergency preparedness exercise The Administrator educated the Dietary Manager regarding the Emergency Food Supply list and the requirement that it be updated annually by the Dietary Manager. This was completed on 05/06/2024. Monitoring: An audit tool was created and contains the following: • A staff contact list is current in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 001	Continued From page 3 monthly. She reported there were missing items from the Emergency Food supply list which included applesauce and nectar thickening. She was not aware the Emergency Food List had not been updated since 2021. An interview was conducted on 4/18/2024 at 10:49 am with the Administrator. The Administrator revealed the only revision that he made to the EP was his name as the Administrator in January 2024. He reported he had not reviewed the staff contact information in the EP and had not noticed it was last updated on 6/18/2021. He reported kitchen staff checked the emergency food supply weekly and he was not aware that any items were missing from the Emergency Food Supply list, and he was not aware the list had not been updated since 4/21/2021 and reported that the emergency food would supply the entire facility (both the Skilled Nursing and Assisting Living units), 127 beds.	E 001	Emergency Preparedness Plan • The emergency food supply menu is current in the Emergency Preparedness Plan and the food items are available • Areas of improvement must be identified, documented and corrected after any table-top or full-scale emergency preparedness exercise The Employee Contact list and Emergency Food Supply list will be reviewed and updated each month at the Quality Assurance and Performance Improvement Committee (QAPI) monthly x 3 months for review and further recommendations. All full-scale community-based drills will be audited monthly X 3 months by the Administrator to ensure compliance with the plan of correction. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the Administrator for review and further recommendations. All corrective actions referenced in this Plan of Correction (POC) will be in place by 5/8/2024.	
F 000	INITIAL COMMENTS An unannounced onsite recertification survey was conducted from 4/15/2024 through 4/18/2024. Event ID #INR311.	F 000		
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		5/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 580 SS=D	Continued From page 4 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 580	Continued From page 5 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician Assistant interviews the facility failed to notify the physician of low blood pressures that required blood pressure medication to be withheld for 1 of 1 sampled resident reviewed for physician notification (Resident #27). The findings included: Resident #27 was admitted to the facility on 10/5/23 with Diagnoses that included atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), and congestive heart failure. Review of Resident #27's active physician orders revealed an order dated 10/18/23 for Metoprolol Tartrate 75 (milligrams) mg oral twice daily for diagnosis of congestive heart failure. There were no heart rate or blood pressure parameters to hold the medication included as part of the order. The quarterly Minimum Data Set (MDS) assessment dated 2/17/24 revealed Resident #27 was cognitively intact.	F 580	Filing the plan of correction does not constitute admission that the deficiencies alleged 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. Resident Affected On 04/16/2024, the Director of Nursing (DON) notified Resident #27 Physician Assistant (PA) of nurses not administering the blood pressure medication for Resident #27 due to low blood pressure on 04/01/2024, 04/02/2024, 04/03/2024, 04/05/2024,04/06/2024, 04/07/2024, 04/12/2024, 04/13/2024, 04/14/2024, and 04/15/2024. On 04/16/2024, a medication review was conducted by the Physician Assistant for Resident #27. New orders were initiated to include blood pressure parameters to guide the nursing staff on when to hold the resident's blood pressure medication. Resident #27 did not suffer any adverse effect related to the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 580	Continued From page 6 Review of Resident #27's electronic Medication Administration Record (eMAR) for April 2024 was completed on 4/16/24 and revealed Resident #27's Metoprolol Tartrate was documented as not administered for the morning dose (9:00 AM dose) on: -4/1/24 -4/2/24 -4/5/24 -4/13/24 -4/14/24 Metoprolol Tartrate was also documented as not administered for the evening dose (5:00 PM dose) on: -4/2/24 -4/3/34 -4/3/24 -4/6/24 -4/27/24 -4/12/24 -4/13/24 -4/14/24 -4/15/24 The morning and evening doses of Metoprolol were documented as non-administered for the reasons: due to condition: low blood pressure or vital signs not with in parameters for administration. There was a blood pressure documented in the non-administration comments on 4/2/24 9:00 AM of 109/61 and on 4/15/24 at 5:00 PM of 97/56. No other vital signs were documented in the medication non-administration notes for Resident #27's Metoprolol Tartrate. Review of Resident #27's vital sign record revealed no documentation of a blood pressure for 9:00 AM or 5:00 PM from 4/1/24- 4/15/24. Review of Resident #27's electronic medical	F 580	Other Residents with potential to be affected All Residents with orders for blood pressure medication have the potential to be affected. An audit of all residents ordered blood pressure medication was completed by the DON on 5/6/24 to ensure that the Physician or PA was notified of any resident whose blood pressure medication was held due to low blood pressure. There were no additional issues identified. No resident suffered any adverse effect related to the alleged deficient practice. Systemic changes The Staff Development Coordinator (SDC) educated all licensed nursing staff and medication aides regarding the policy on “Notification of Resident Condition or Status” specifically related to blood pressure medication, blood pressure medication parameters, and notifying physician and resident/resident representative in the event blood pressure medication is held. This was completed on 05/07/2024. Any licensed nursing staff or medication aide out on leave or PRN (as needed) status will be educated on this prior to returning to duty by the SDC. This information is provided to all licensed nursing staff and medication aides during orientation by the SDC or designee. Monitoring A Blood Pressure Medication Monitoring Tool was implemented to ensure blood pressure medication is administered as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 580	Continued From page 7 record revealed there was no documentation in the nursing notes or physician progress notes about Resident #27's low blood pressure or the physician being notified of Resident #27's low blood pressure. An interview with Nurse #5 was performed on 4/16/24 at 9:00 AM. Nurse #5 stated she worked on the 600-hall extension hall routinely and administered medications. She stated she would hold Resident #27's Metoprolol Tartrate sometimes because "her blood pressure is too low". Nurse #5 reviewed Resident #27's eMAR and verified there were no parameters included with the order for holding the medication. Nurse #5 explained she used blood pressure parameters of 110/60 to hold Resident #27's Metoprolol Tartrate. She stated she used these parameters based on her prior nursing experience knowledge and because another blood pressure medication scheduled at a different time had parameters of 110/60. Nurse #5 stated there was not a facility standing order for blood pressure parameters to hold blood pressure medications. She stated she had not called the providers to notify them of Resident #27's low blood pressures or that she held Resident #27's Metoprolol Tartrate due to low pressure. An interview was performed on 4/16/24 at 3:54 PM with Nurse #4. She explained she checked Resident #27's blood pressure and if her blood pressure was less than 110/60, she would hold Resident #27's Metoprolol Tartrate. She explained Resident #27's blood pressure tended to run low. She stated "going off nursing knowledge" she used blood pressure parameters of 110/60 to hold the Metoprolol Tartrate. Nurse #4 said she did not	F 580	ordered, and if held, proper notification of physician and resident/resident representative is completed. The DON/designee will audit 10 residents per week x 4 weeks, then every other week x 4 weeks, then monthly x 1 month to ensure continued compliance. The results of the monitoring tool will be brought to the monthly Quality Assurance and Performance Improvement Committee x 3 months by the DON for further review and recommendations. Completed: 05/08/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 580	Continued From page 8	F 580		

notify the Physician of Resident #27's low blood pressure or that the medication was held. Nurse #4 stated the physician should be notified if a blood pressure mediation was held so they can add parameters to the medication.

An interview was performed on 04/16/24 at 12:19 PM with the Physician Assistant (PA). She stated she was unaware that Resident #27's Metoprolol was being held frequently due to low blood pressures. The PA stated she had not been made aware that Resident #27 was having low blood pressure. She said if a resident's blood pressure was low a nurse could hold a blood pressure medication once per nursing judgement. The PA explained if a blood pressure medication had frequently needed to be held more often than once or twice, she would expect the nurses to notify her. She stated if she had been notified and new Resident #27's Metoprolol Tartrate was frequently being held she would have given orders for parameters.

An interview was performed with the Director of Nursing (DON) on 4/16/24 at 4:09 PM. She reviewed the eMAR for Resident #27's Metoprolol Tartrate administration history. The DON stated looking at the non-administration history for Resident #27's Metoprolol Tartrate she did not feel like there was a "trend" in the medication not being administered due to low blood pressure. She said she thought nurses should notify the physician if there was a trend in low pressure and a trend in the medication not being given due low blood pressures. She explained a trend would be the same time of day for several days in a row. She did not comment on if she considered Resident #27 having low pressure for 4 days in a row at 5:00 PM as a trend.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 580	Continued From page 9 An interview was performed on 04/17/24 at 3:47 PM with the Administrator. He stated the Physician should be notified if a resident was having low blood pressures and should be involved in the decision to hold medication.	F 580		
F 585 SS=E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through	F 585		5/7/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 10	F 585		

postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 11 (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, family member, and staff interview the facility failed to implement their grievance policies and procedures when Resident #222's Resident Representative reported the resident's top dentures were missing and when Resident #20 requested a call bell extension cord to be added in her bathroom for 2 of 2 residents reviewed for grievances (Resident #222 and Resident #20). The findings included: 1. Resident #222 was admitted to the facility on 3/22/2024 with a diagnosis of vascular dementia. Review of the Inventory of Personal Items	F 585	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. Affected resident Resident #222’s dentures were not found. The Administrator notified Resident #222’s spouse, and an appointment was made on 04/16/2024 for Resident #222 with a dentist for denture replacement.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 12 documentation dated 3/22/2024 completed by Nurse #3 revealed Resident #222 was admitted with upper dentures. An admission Minimum Data Set (MDS) dated 3/26/2024 revealed Resident #222 was severely cognitively impaired. Resident #222 was not coded for dentures. Review of a nursing note dated 3/31/2024 completed by Nurse #1 revealed Resident #222's representative had reported his upper dentures were missing. Review of a handwritten grievance form dated 4/3/2024 revealed on 3/31/2024 at 10:30 am, Resident #222's family member reported his top dentures were missing. The space on the form indicating who received the grievance was blank. The investigation documentation revealed 'maybe we can look in her room as well.' The grievance was signed by the Director of Nursing (DON) and was dated 4/3/2024. The grievance was missing the conclusion, corrective action, and communication with the family member. An observation was conducted on 4/15/2024 at 1:22 pm. Resident #222 was up in his wheelchair and was not wearing upper dentures and was edentulous where upper teeth should be located. An observation and interview were conducted on 4/16/2024 at 8:48 am. Resident #222 was up in his wheelchair and was not wearing upper dentures and was edentulous. He reported he had not worn his dentures because he had not been able to find them. A telephone interview was conducted on	F 585	Resident #222's spouse was satisfied with the resolution. The conclusion and resolution was documented on the Grievance Reporting Form by the Administrator on 4/16/2024 to complete the process. Resident #20's call light cord in the bathroom was extended by the Maintenance Director so it could reach across the sink to aid the resident in reaching the call light from her wheelchair. This was completed on 4/2/2024. Resident #20 was satisfied with the resolution. The conclusion and resolution were documented on the Grievance Reporting Form by the Administrator on 4/16/2024 to complete the process. Residents with potential to be affected All residents have the potential to be affected by the alleged deficient practice. By 5/6/2024, the Social Services Director or designee, reviewed all Grievance Reporting Forms for the past 90 days to see if the grievance had been completed with a conclusion, corrective action and proper notifications were made. Any incomplete Grievance Reporting Forms were completed by the Social Services Director by 5/7/2024. No resident suffered any adverse effect related to the alleged deficient practice. Systemic changes The Corporate Compliance Manager educated the Administrator on the Grievance Reporting policy on 05/06/2024 to include the requirement that all Grievance Reporting Forms are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 13 4/17/2023 at 11:19 am with Resident #222's representative. The representative stated she reported to the SW that Resident #222's dentures were missing on 3/31/2024. She reported she had gone to the SW's office and the SW filled out the grievance form. She reported she had not been contacted regarding the conclusion of the investigation until this morning (4/17/2024). She stated the Administrator told her 'They did not know what they could do about it' and stated the Administrator offered to take him to the dentist but she declined because he would be discharged home by that time. An interview was conducted on 4/17/2024 at 1:36 pm with the DON. The DON stated a grievance was to be completed when there was a concern or complaint and she preferred grievance forms to be completed by the Charge Nurse. She reported the Administrator was the Grievance Official and was responsible for ensuring that everyone involved in the grievance was satisfied. She stated after a grievance was filed, copies of the grievance were given to her, the SW, and the Administrator and the investigation would be initiated. She reported investigative steps taken should be documented on the grievance form as well as the conclusion and corrective action within 5 days of being notified about the grievance. The DON reported she had not investigated Resident #222's grievance and verified that her signature was on the grievance. She reported that the grievance policy and procedures had not been followed for Resident #222 because facility staff were still looking for the missing dentures and they had not reached a conclusion after 5 days. A telephone interview was conducted on 4/16/2024 at 3:23 pm with Nurse #1. Nurse #1	F 585	completed, with conclusion, resolution and proper notifications and that they are signed by the Administrator. On 05/06/2024, the Administrator educated the Social Services Director and Director of Nursing on the Grievance Reporting Policy and the correct process for fully completing a grievance form and verification of all completed actions. All staff were educated on 05/06/2024 by the Staff Development Coordinator on the Grievance Reporting Policy. Any staff who did not receive education will not be allowed to work until the education is completed. Monitoring An audit tool was created to ensure compliance with the Grievance Reporting Policy. The Administrator/designee will audit all grievances filed weekly x 4 weeks, then monthly x 2 months to ensure that the Grievance Reporting Forms are completed per policy. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the Administrator for review and further recommendations. All corrective actions referenced in this Plan of Correction (POC) will be in place by 5/7/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 14	F 585		

stated the family member of Resident #222 had reported to her that his upper dentures were missing on 3/31/2024. She reported that she looked all over his room and the nurse's station for his dentures and was not able to locate them. Nurse #1 stated she wrote a note in Resident #222's chart and reported the missing upper denture to the Charge Nurse #1 but had not filed out a grievance because she had never been instructed to. She verbalized that she was never able to find the dentures.

An interview was conducted on 4/16/2024 at 3:28 pm with the Charge Nurse #1. Charge Nurse #1 verbalized she had been made aware of Resident #222's missing dentures and looked in his room, common areas in the facility, and the desk at the nurse's station and had not located them. She reported when an item was missing staff should look for the item and notify laundry, dietary, the Social Worker (SW), and admissions. She stated she had not filled out any documentation for the missing item and was not aware grievances should be completed if a resident or resident representative had voiced a concern.

An interview was conducted on 4/16/2024 at 3:32 pm with the SW. The SW reported a grievance was completed whenever there was a concern or a complaint. She reported any staff member, resident, or family member were allowed to complete a grievance. She reported after a grievance was filled out, the staff member would put it under her door, in her mailbox, or in the mailbox of the DON or administrator. The SW stated staff from all departments then completed the investigation process and she would speak with the staff, resident, and/or resident representative. She also reported that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 15	F 585		

grievances were discussed in the morning clinical meetings.

A follow-up interview was conducted on 4/17/2024 at 11:26 am with the SW. The SW reported that she filled out the grievance when the representative for Resident #222 had reported his upper dentures were missing. The grievance was reviewed during the interview. The SW was not sure why the date the form was filled out and the date the incident took place did not match, and verbalized a grievance should be completed immediately when an issue was brought to a staff member's attention. She reported she also brought the concern up in the 4/1/2024 morning meeting. She reported she had given a copy of the grievance to the DON and the Administrator on an unknown date. She reported she had spoken to the representative after the grievance was filed, but was unsure of the date, about the missing item when the representative informed her that the dentures would cost $1800 to replace. The SW stated that Resident #222 had dementia and could have thrown the dentures in the trash or left them on a tray that was returned to the kitchen. She reported the Administrator was the Grievance Official and that the grievance process should have resulted in a conclusion within 5 days of the grievance being filed. She reported the grievance process had not been followed because they had continued to look for the missing dentures and had not come to a conclusion or completed the form within 5 days.

An interview was conducted on 4/18/2024 at 10:35 am with the Administrator. The Administrator stated that he was the Grievance Official. He stated a grievance could be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 16	F 585		

completed by staff, visitors, residents, and family members. He stated the SW typically filled out grievances and distributed copies to all the department managers after a grievance was completed. He reported the investigation was started, and a resolution would be identified and implemented. He stated the goal for having a grievance completed was 5 days unless there was an ongoing investigation. The Administrator was aware the DON was assigned the grievance for Resident #222 and reported she had looked for the dentures. He stated he, as the Grievance Official, had not yet come to a conclusion nor implemented any corrective actions within 5 days of the grievance being filed. He stated that he completed the remainder of the grievance form on 4/16/2024 and he had not contacted the representative until 4/17/2024 at which time he informed the representative that Resident #222's dentures had not been located. He reported he offered to make a dentist appointment and the representative declined because the appointment could not be made until after Resident #222 had been discharged, which was scheduled for 4/19/2024.

2. Resident #20 was admitted to the facility on 08/01/19

Review of a handwritten grievance form dated 11/28/23 revealed Resident #20 requested a call bell pull cord for her bathroom. The space on the form indicated the nursing department had received the grievance and was documented in parenthesis as 'taken care of.' The grievance was missing the conclusion, corrective action and required signatures from the Director of Nursing (DON) and the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 17	F 585		

A quarterly Minimum Data Set (MDS) dated 03/12/24 revealed Resident #20 was cognitively intact.

An interview was conducted with Resident #20 on 04/17/24 at 1:13 PM. Resident #20 stated she was not able to move or propel her manual wheelchair to reach the call bell in the shower or the call bell next to the toilet because the pull cords were "just not long enough." Resident #20 reported she had filed a grievance requesting a longer pull cord to be added to her bathroom call bell multiple times and nothing had been done.

An interview was conducted with the Maintenance Director on 04/17/24 at 3:50 PM who stated that he was not aware and had not received a grievance request for Resident #20 needing a longer pull cord for the bathroom. He reported when residents had a maintenance request or issues he received the grievance form request from administration, then entered a work order request into their electronic work order request system. The Maintenance Director was observed reviewing work orders and stated that Resident #20 didn't have a work order request in the system. He further stated adding a longer pull cord to the call bell was a "quick fix" and could be done on the same day.

An interview was conducted with the Director of Nursing (DON) on 04/18/24 at 9:00 AM who stated a grievance could be initiated by a staff member, the resident or family member and during resident council meetings. She stated when a grievance was initiated the staff helped complete the form, the administration team reviewed each grievance form to determine which department or area needed to address the issue

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 585	Continued From page 18 or concern. The DON stated they held daily meetings with all staff members in the morning to discuss issues and concerns that will be addressed; and that the Administrator also reviewed and kept a copy of each grievance form until it had been completed. She verbalized if the issue was related to nursing care, she completed that portion of the form and made sure the issue was addressed. She also verbalized being aware of Resident #20's request for a longer pull cord for the call bell in her bathroom and thought the issue was taken care of "back in November 2023." However, she mentioned "she had let the ball drop" and would make sure Resident #20's request for a longer pull cord would be taken care of today (04/18/24). An interview was conducted with the Administrator on 04/18/24 at 9:30 AM who stated the departments were responsible for addressing the residents' grievances. He continued to state once the grievance had been handled, he reviewed and signed off on the form. He indicated he thought Resident #20's grievance was resolved previously. He acknowledged that their grievance policy was not followed.	F 585		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to follow a	F 658	Filing the plan of correction does not constitute admission that the deficiencies	5/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 658	Continued From page 19 physician's order to apply compression stockings for 1 of 1 resident (Resident #220) reviewed for edema. The findings included: Resident #220 was admitted to the facility on 3/11/2024 with diagnoses which included cellulitis (bacterial infection that can result in swelling and inflammation) of the left lower limb, localized edema (swelling), and lymphedema (swelling as a result of built-up lymph fluid in the body). An admission Minimum Data Set (MDS) assessment dated 3/15/2024 revealed Resident #220 was cognitively intact. A review of Resident #220's physician orders revealed an order dated 4/5/2024 to apply compression stockings to bilateral lower extremities upon rising and to remove at night before bed daily. A review of Resident #220's care plan dated 4/11/2024 revealed she was admitted with weeping areas of the lower extremities related to a diagnosis of cellulitis and was at risk for further areas of skin breakdown related to edema, weeping, lymphedema, and cellulitis. Interventions included staff were to provide treatment to weeping areas on lower extremities as ordered. A review of Resident #220's MAR for the month of April 2024 revealed Nurse #2 documented she had applied Resident #220's compression stockings on 4/16/2024. An interview and observation were conducted on	F 658	alleged 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 of care. Affected Resident Nursing staff applied compression stockings to Resident #220 on 4/16/24 as ordered. On 04/16/2024, the Director of Nursing reviewed the medical record of Resident #220, which indicated that Resident #220 frequently refuses to wear compression stockings. The Physician Assistant was notified on 04/16/2024 and she discontinued the compression stockings for Resident #220 on 4/26/24. The resident did not suffer any adverse effect related to the alleged deficient practice. Other residents with potential to be affected All Residents with physician orders for compression stockings have the potential to be affected. An audit was completed by the Director of Nursing (DON) on 5/7/24 to identify all current residents with physician orders for compression stockings to ensure compliance with the physicians' order. No other issues were identified. No resident suffered any adverse effects related to the alleged deficient practice. Systemic Changes The Staff Development Coordinator (SDC) educated all licensed nursing staff regarding the requirement to follow	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 658	Continued From page 20 4/16/2024 at 11:32 am with Resident #220 after she returned from working with Physical Therapy. Resident #220 was observed sitting in her wheelchair with her feet on the floor and did not have compression stockings on. She stated she wore compression stockings because she had experienced significant swelling. She reported the nursing staff had not put her compression stockings on and had told her that they could not find her compression stockings. Resident #220 also stated a staff member, whose name she was not able to remember, had told her they did not have any to replace them at that time. An empty extra, extra-large (XXL) compression stocking wrapper was observed on her nightstand beside her bed. She reported she always told staff to put them in her top nightstand drawer when they took them off, but stated staff had not done that, and that they were no longer there. Resident #220 opened her top nightstand drawer, which did not contain compression stockings. A telephone interview was conducted on 4/18/2024 at 9:02 am with Nurse #2. Nurse #2 reported she worked third shift (11:00 pm to 7:00 am) on 4/16/2024 and verbalized she had documented applying Resident #220's compression stockings. She stated that she had not put the compression stockings on Resident #220 and had asked a Nurse Aide (NA) that morning (4/16/2024) whose name she was not able to recall, to put them on the resident. Nurse #2 reported she had not checked to ensure the NA had placed the compression stockings on the resident because she was busy and 'it happens.' She reported the compression stockings should have been placed on Resident #220 per physician's order.	F 658	physician orders for all residents with physician orders for compression stockings. This was completed on 05/07/2024. Any licensed nursing staff out on leave or PRN (as needed) status will be educated by the SDC/designee prior to returning to duty. Any newly hired licensed nursing staff are educated on this process by the SDC/designee during orientation. Monitoring An audit tool was developed to ensure application of compression stockings per physician order. These audits will be completed by the SDC on 25% of residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will be brought to the monthly Quality Assurance and Performance Improvement Committee Meeting by the DON x 3 months for review and further recommendations. Completion date 5/8/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 658	Continued From page 21	F 658		

An interview was conducted on 4/16/2024 at 11:38 am with Nurse #1. Nurse #1 reported compression stockings were ordered for Resident #220 to be applied daily. She reported that the third shift (11:00 pm to 7:00 am) nursing staff, either a Nurse or an NA, were responsible for applying compression stockings when they had gotten Resident #220 up in the morning. She verified that Nurse #2 had documented applying the compression stockings at 6:33 am on 4/16/2024.

An observation of Resident #220 was conducted with Nurse #1 4/16/2024 at 11:40 am. During the observation, Nurse #1 verified that Resident #220 was not wearing compression stockings. Nurse #1 reported if it was charted, she would have expected the compression stockings to be on Resident #220.

An interview was conducted on 4/18/2024 with the Director of Nursing (DON). The DON reported extra compression stockings were kept in stock in the facility and were readily available for staff to obtain for residents. She reported NAs or nurses could put compression stockings on the resident. The DON stated application of compression stockings was typically documented on the Electronic Medical Record (EMR). She reported that Nurse #1 notified her that on 4/16/2024 Resident #220 did not have the compression stockings on her legs and Nurse #1 had applied the compression stockings after she was made aware of the error. The DON reported the compression stockings should have been placed on Resident #220 as ordered.

An interview was conducted on 4/18/2024 at 10:41 am with the Administrator. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 658	Continued From page 22 Administrator reported compression stockings were kept in the facility and if they were ordered to be applied daily then the staff should have applied them daily. An interview was conducted on 4/18/2024 at 11:30 am with the Physician's Assistant (PA). The PA stated Resident #220 had experienced swelling of her bilateral lower extremities and was ordered to have compression stockings applied daily.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, sitter and staff interviews, the facility failed to provide assistance with dressing when requested for 1 of 3 dependent resident (Resident #367) reviewed for provide care with activities of daily living (ADL). The findings included: Resident #367 was admitted on 04/03/24 with the diagnosis of muscle weakness, unsteadiness on feet and chronic pain. A review of the care plan for Resident #367 dated 04/11/24 indicated the resident had impaired mobility and required partial to maximum assistance with activities of daily living (toileting, dressing and bathing).	F 677	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. Affected Resident The alleged deficiency for Resident #367 could not be corrected at the time of receipt of the 2567. Resident #367 has discharged from the facility. Resident #367 did not suffer any adverse effect related to the alleged deficient practice. Other residents with potential to be	5/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 677	Continued From page 23 A review of the Minimum data Set indicated Resident #367 required partial to max assist with toileting, dressing, positing, supervision of feeding, tray set up, chronic pain, occupational therapy (OT) and physical therapy (PT), and moderately impaired cognition with short term memory problems. An interview with Resident #367 on 04/15/24 at 11:37 AM, revealed that she had asked to be dressed in regular clothes (pants and blouse) before lunch, but nurse aide (NA) #7 told her she had a sitter to dress me in the morning and I should have told asked my sitter. The Resident stated she then told the NA she wasn't quite ready to get dressed before breakfast when her sitter was with her. She then revealed she wanted to change out of her gown and wear real clothes for therapy session scheduled for after lunch. Observation of Resident #367 at the time of the interview revealed she was wearing a nightgown. An observation on 4/15/24 11:40 AM, of resident #367's closet, revealed she had several changes of clean clothes. An observation of Resident #367 on 04/15/24 at 02:35 PM, revealed that she had not been dressed in her regular clothes at this time. She was still wearing the nightgown she had been wearing that morning. An interview with NA#7 on 04/15/24 at 03:26 PM revealed when asked about dressing resident#367, she indicated that the resident had a paid caregiver that bathes and dresses her, so she needed to tell the caregiver when she is getting dressed, that she wants to put on regular	F 677	affected. All residents needing assistance with dressing have the potential to be affected. All alert and oriented residents that require assistance with dressing were interviewed by the DON or Nursing Supervisor. There were no additional issues identified. Grievance reporting forms for the past 30 days were reviewed by the DON to ensure that no additional resident or resident representative had any concerns regarding the resident being dressed. There were no identified concerns regarding any resident being assisted with dressing. No additional resident suffered any adverse effect related to the alleged deficient practice. Systemic changes All Certified Nursing Assistants (CNA) were educated by the Staff Development Coordinator (SDC)/designee on assisting residents with dressing, as requested and/or as needed. This was completed by 5/7/2024. Any CNA out on leave or PRN (as needed) status will be educated by the SDC/designee prior to returning to duty. All newly hired CNA's are educated on activities of daily living (ADL) care, including dressing, during orientation by the SDC/designee. Monitoring An audit tool was developed to monitor for assisted dressing. The Director of Nursing (DON) or designee will complete these audits on 5 residents weekly for 4 weeks, then biweekly x 4 weeks, then monthly x 1 month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 677	Continued From page 24 clothes. An interview with Resident #367 on 04/16/24 at 08:37 AM, indicated that she did not get dressed in her regular clothes on 4/15/24, they were still lying over her chair this morning. An interview with the sitter on 04/16/24 at 9:00 AM revealed that she comes every morning to give her a bath, and it is sometimes early, so Resident #367 was not ready to get dressed until after breakfast the morning of 04/15/24. She further revealed that if the Resident had therapy in the afternoon she wanted to wait to get dressed later. An observation of Resident #367 on 04/16/24 at 9:00 AM, revealed she had been dressed in her regular clothes by the sitter. An interview with the DON 04/17/24 at 10:17 AM, revealed that her expectations are that the NA #7 regardless of a sitter still complies with her duties. An interview with Administrator on 04/17/24 at 02:18 PM, revealed his expectation would be for the NA #7 to assist as needed when Resident #367's sitter was present and after the sitter leaves to continue with her duties. An interview with the Administrator on 04/18/24 at 10:30 PM, revealed it was his expectation that regardless of if the residents had a sitter or not, that the NA#1 would assist as needed, and when the sitter left, they would continue with their duties caring for the resident's needs. An interview with the Therapy Director on 04/18/24 at 11:47 AM, indicated that Resident #367 was receiving physical and occupational therapy. They were working on upper and lower	F 677	The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the DON for review and further recommendations. All corrective actions referenced in this Plan of Correction (POC) will be in place by 5/8/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 677	Continued From page 25 body strengthening for positioning and dressing, toileting, and bathing. He further stated that the Resident was making progress but was unsafe to get up and dress without assistance.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff and Physician Assistant interivews the facility failed to follow physician orders to check a diabetic resident's (Resident #27) blood sugar levels twice daily for 1 of 1 resident reviewed. The findings included: Resident #27 was admitted to the facility on 10/5/23 with diagnoses that included diabetes mellitus type 2 (a condition when your blood sugar is too high) Review of Resident #27's active physician orders for April 2024 revealed an order dated 12/4/23 to: check blood sugar twice daily at 6:00 AM and 4:30 PM for diagnosis of type 2 diabetes mellitus. Resident #27 did not have orders for insulin. The quarterly Minimum Data Set (MDS)	F 684	Filing the plan of correction does not constitute admission that the deficiencies alleged 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 of care. Affected Resident The Director of Nursing (DON) completed a medical record review for Resident #27 on 04/16/2024 specifically related to Diabetes diagnosis and physician order for blood sugar levels. Her glucose level was checked on 04/29/2024 and remained within normal limits. Resident #27 has experienced no negative effect related to the alleged deficient practice. The physician order for blood sugar check twice daily was discontinued by the	5/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 684	Continued From page 26 assessment dated 2/17/24 revealed Resident #27 was cognitively intact. Review of Resident #27's care plan revised 2/19/24 revealed she did not have a care plan specific for Type 2 diabetes mellitus. Review of Resident #27's electronic Medication Administration Record (MAR) for April 2024 did not show blood glucose checks twice daily at 6:00 AM and 4:30 PM being completed. A review of Resident #27's electronic health record was conducted. There were no blood glucose check results documented in the resident's record. An interview was conducted with Resident #27 on 4/16/24 at 8:40 AM. She stated she checked her blood glucose at home prior to coming to the facility but said she had never had her blood glucose checked since she had been admitted to the facility. An interview was conducted on 4/16/24 at 9:00 AM with Nurse #5. She stated she regularly worked on the 600-hall and administered medications to Resident #27. She said she did not check Resident #27's blood glucose. An interview was conducted on 4/16/24 with the Physician Assistant (PA). She stated she was not aware of an order to check Resident #27's blood glucose twice daily. The PA reviewed Resident #27's active orders and verified there was an order for Resident #27 to receive blood glucose checks twice daily. The PA opened the order entry details for the blood glucose check order and explained the order was put in incorrectly.	F 684	physician on 4/16/24. Other Residents with potential to be affected An audit was completed by the DON on 5/8/24 to identify all current residents with diagnosis of Diabetes and orders for blood sugar checks. All orders have been confirmed as transcribed correctly to the medication administration record, completed and entered into the electronic medical record accordingly. No other resident suffered any adverse effects related to the alleged deficient practice. Systemic Changes The Staff Development Coordinator (SDC) educated all licensed nursing staff regarding physician order entry into the electronic medical record and to ensure that physician orders are entered onto the correction medication administration flowsheet. This was completed on 5/9/2024. Any licensed nursing staff out on leave or PRN status will be educated by the SDC prior to returning to duty. This education is provided by the SDC to all newly hired licensed nursing staff during orientation. In addition, the transcription of physician orders will be validated daily by the DON/designee Monday through Friday during clinical meeting and by the Nursing Supervisor on the weekends to ensure correct transcription of physician orders for blood sugars. Monitoring An audit tool was developed to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 684	Continued From page 27 She said because the order was put in incorrectly the order would not have popped up on the MAR for the nurses to see and know they needed to check Resident #27's blood glucose. An interview was performed with the Charge Nurse on 4/16/24 at 2:59 PM. She explained the process for entering orders in the electronic medical record. She stated sometimes verbal orders were given by the provider and then entered in the electronic medical record by the nurse. The Charge Nurse said there was not a process for orders to be checked by a second nurse. She explained when an order was entered into the electronic medical record there were different aspects of the order that needed to be entered when inputting the order that would tell the order where to show up, such as on the MAR and what time to populate on the MAR. She opened the order entry details for Resident #27's order for blood glucose checks and verified she was the nurse who inputted the order. The charge nurse explained the order did not appear on the MAR for the nurses to see because the order was entered incorrectly under the flow sheet titled "general" and this flow sheet did not pull orders to the MAR. An interview was performed on 4/17/24 at 3:35 PM with the Director of Nursing (DON). The DON was aware Resident #27 had not received blood glucose checks due to the order being entered incorrectly into the electronic medical record. She stated she was unsure of what happened in the process other than "human error". The DON said it was easy to miss click when entering an order. The DON stated there was not a second person who checked orders when orders were put in by a nurse. She stated the nurses checked and	F 684	blood sugar orders are transcribed correctly according to the physician order. These audits will be completed by the SDC/designee on 25 percent of residents 3x/week x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will be brought to the monthly Quality Assurance and Performance Improvement Committee meeting by the DON for 3 months for further review and recommendations. Completion date: 5/9/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 684	Continued From page 28 verified orders when the order was put in by the physician. An interview was performed on 04/17/24 at 03:36 PM with the Administrator. He was made aware Resident #27 had not received blood glucose checks due to the order being entered incorrectly into the electronic computer system. He stated he thought there should have been a follow up to the order, such as a second check. He said physician orders should be followed and was unsure of what happened in this situation.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		5/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 690	Continued From page 29 receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and Physician Assistant interviews, the facility failed to maintain infection control when staff reused urinary leg drainage bags, urinary bedside drainage bags, and connection tubing causing an increased risk of infection. This occurred for 1 of 1 resident (Resident #17) reviewed for catheter care. The findings included: Resident #17 was re-admitted to the facility on 8/21/23 with Diagnoses that included obstructive uropathy with urinary retention. Review of Resident #17's active physician orders for April 2024 revealed an order dated 8/29/23 that read: Place leg bag on in the AM (morning) and off at HS (bedtime). Special instructions: please remove the leg bag at bedtime and put on catheter bag while in bed. Additional orders dated 12/21/23 read: Catheter to straight drainage bag related to obstructive uropathy; Catheter care every shift; catheter change as needed for obstruction, infection, or when otherwise clinically indicated; secure strap, privacy bag and monitor	F 690	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. Affected resident The foley catheter bag for Resident #17 was changed by the Director of Nursing (DON) on 4/18/2024. Any old catheter and/or leg bags in room were discarded by the DON on 4/18/2024. NA #1, Nurse #4 and Nurse #5 were educated by the Staff Development Coordinator (SDC) on 04/18/2024 on the correct process for cleaning of catheter ports when changing drainage bag, changing from foley drainage bag to leg bag and the disposal of foley drainage bags and leg bags after each use. Resident #17 did not suffer any adverse effects related to the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 690	Continued From page 30 every shift. The quarterly Minimum Data Set (MDS) assessment dated 1/13/24 revealed Resident #17 was cognitively impaired and had an indwelling catheter. Review of Resident #17's care plan revised 4/18/24 revealed a care plan for an indwelling urinary catheter related to urinary retention due to obstructive uropathy. The care plan interventions included: catheter care every shift and as needed, keep catheter system a closed system as much as possible, change catheter per doctor order, assess drainage every shift, avoid obstructions in drainage, position bag below level of bladder, report any signs of urinary tract infection (UTI), Do not allow tubing or any part of the drainage system to touch the floor. 4/16/24 08:20 AM an observation was made of Resident #17 up in her wheelchair outside of her room. She was wearing long pants, and a catheter drainage bag was not visible. An interview was performed on 4/16/24 at 8:48 AM with NA #1. She explained Resident #17 used a leg urinary drainage bag when she was up during the daytime and was changed to a bedside drainage bag at night. NA #1 stated she switched Resident #17 from the bedside drainage bag to the leg drainage bag when she got her up in the mornings. She explained how she switched Resident #17's urinary drainage bags. She said she wore a gown and gloves when she provided catheter care. NA #1 stated she sometimes would use a new leg bag when she switched the Resident #17's catheter over from the night side drainage bag in the mornings. She said she	F 690	Residents with potential to be affected There are no additional residents with catheters in the facility. No resident suffered any adverse effect related to the alleged deficient practice. Systemic changes On 5/6/2024, the SDC educated all licensed nursing staff, Medication Aides and Certified Nursing Assistants (CNA) on the policy and procedure for cleaning of catheter ports when changing drainage bag, changing from foley drainage bag to leg bag and the disposal of foley drainage bags and leg bags after each use. This was completed on 5/6/2024. Any licensed nursing staff, medication aide, or CNA out on leave or PRN (as needed) status will be educated prior to returning to duty by the SDC/designee. All newly hired licensed nursing staff, medication aides, and CNA's are educated on the policy and procedure during orientation by the SDC/designee. Monitoring An audit tool was developed to monitor the changing of foley drainage bags to leg bags, cleaning of the catheter ports, and disposal of used foley drainage bags and leg bags per policy. The Director of Nursing (DON) will audit 100% of residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the DON for review and further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 690	Continued From page 31 stored the used leg urinary drainage bag in the bathroom between uses. She stated she would reuse the leg bag a couple of days sometimes before getting a new one. She said the bedside drainage bag was reused and she would place the bedside drainage bag into a plastic bag in the bathroom when it was not in use. NA #1 stated she was unsure how long the bedside drainage bag was reused. She explained when she changed Resident #17's catheter from the bedside drainage bag to the leg bag she would sometimes wipe the tubing connection tip off with "a rag or baby wipe" before connecting it to the catheter. She explained a "baby wipe" as being an incontinent care wipe. She stated she would typically leave Resident #17's leg bag on if she laid down for a nap. She explained Resident #17 would typically lay down for a nap in the afternoon for several hours every day. NA #1 stated she had not received specific training on how to switch a catheters connection from a leg drainage bag to a bedside drainage bag. She said she had not been told when catheter bags needed to be changed or how to store them if they were reused. An observation was completed on 4/16/24 at 9:00 AM of the urinary bedside drainage bag stored in the bathroom cabinet in a wash basin, no cap was present on the tip of tubing, old urine was visible in the bag, the urinary collection system was not stored in a bag, the date on the back of drainage bag was 4/24. An Interview was completed on 04/16/24 at 3:46 PM with Nurse #4. She stated she worked on the 600-hall extension on the weekends for 7:00 AM-7:00 PM shift. She stated she typically switched Resident #17's catheter between urinary drainage	F 690	All corrective actions referenced in this Plan of Correction (POC) will be in place by 5/6/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 690	Continued From page 32	F 690		

bags. She said she would not expect an NA to do that task. She explained how she switched Resident #17's catheter from the bedside drainage bag to the leg drainage bag. She said she would empty the bag, disconnect the catheter from the bedside drainage bag tubing, clean off the end of the tubing of the leg drainage bag and reattach it to the catheter. She stated she cleaned the tubing tip with an alcohol wipe before reattaching it to the catheter. Nurse #4 said she thought the bedside drainage bags were changed every month. She stated when the leg urinary drainage bag was removed, it was placed in the bathroom. She said the urinary drainage bag was placed on top of the toilet to be stored, she said she did not place the drainage bag in plastic bag for storage. She stated, "it is usually just on top of the toilet". She explained, the bedside drainage bag was also kept on top of the toilet between use and stated, "it is not stored in anything, it is just on top of the toilet". She stated leg urinary drainage bags are used she thought for a month before they were changed. She did not say what day of the month the urinary drainage bags were changed or how staff new when to change the urinary drainage bags.

An observation was completed on 04/17/24 at 8:10 AM. Resident #17 was observed in bed with her eyes closed. She had a bedside urinary drainage bag in place. The leg urinary catheter drainage bag was observed stored in the bathroom cabinet in a wash basin, with dark old urine visible in the bag, no cap was present on the end of tubing, the leg bag was not stored in a plastic bag, the leg bag was not dated.

An observation was completed on 04/18/24 at 8:30 AM of the bedside urinary drainage bag with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 690	Continued From page 33	F 690		

attached tubing, in a plastic bag, stored on the back of the toilet, the urinary drainage bag was dated 4/17.

An interview was performed on 4/18/24 with Nurse #5. She explained Resident #17's NA switched her urinary drainage bag between the leg bag and bedside drainage bag when they assisted Resident #17 to get up out of bed and when they lay her down. Nurse #5 said the urinary drainage bag not being used at that time was put in the cabinet of Resident #17's bathroom. She said she thought she had seen the urinary drainage bag not in use stored "in something like a bag sometimes but not every time". Nurse #5 stated urinary drainage leg and bedside bags were not changed daily, that the bags were reused. She said she thought Resident #17's urinary drainage leg and bedside bags were changed monthly and then as needed if the bags were dirty or there was a lot of sediment in the tubing. Nurse #5 stated the urinary drainage bags tubing connection tip should be cleaned with an alcohol wipe before reconnecting it to the catheter. She stated no one from the facility had ever talked to her about how often urinary drainage bags should be changed, how to maintain them, where to store them between uses, or how to store them.

An interview was performed on 4/18/24 at 8: 53 AM with the Staff Development Coordinator (SDC)/ Infection Preventionist (IP). He stated when a catheter was disconnected from the tubing/ urinary drainage bag he would expect staff to get a new bag. He said NA's received generalized training on catheter care but had not received training specificly on the process of disconnecting and reconnecting a catheter from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 690	Continued From page 34	F 690		

the urinary drainage tubing/ bag. He stated the facility did not have specific policy and procedures on the reuse of urinary drainage bags, or how to maintain and store them. The SDC stated he was unsure if an NA could perform the task of disconnecting the catheter and switching it between a leg and bedside drainage bag. He stated he assumed the nurse would perform the task and not the NA but was unsure. He said the urinary drainage bag connected to the catheter was changed as needed and if the catheter was changed. The SDC explained if the urinary drainage bag was disconnected from the catheter frequently it would open the closed system, which was not recommended because this would introduce infection. The SDC called the Director of Nursing (DON) to his office for clarification on urinary leg and bedside bag reuse. The DON and the SDC both said urinary drainage bags should not be reused. They stated that staff should use a new bag each time the catheter was disconnected to switch between a leg and bedside drainage bag.

An interview was performed with the DON on 4/18/24 at 10:34 AM. She stated staff should throw away the used urinary drainage bag and get a new bag each time the catheter was disconnected to switched between a leg and bedside drainage bag. She stated the urinary drainage bag with attached connection tubing should be changed as needed and anytime the closed urinary drainage system was opened. She stated anytime the closed system was opened bacteria could be introduced that could cause an infection. She stated indwelling urinary catheters were changed as needed and not monthly or routinely unless ordered by the urologist. She explained the process for switching a catheter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 690	Continued From page 35 between a leg and bedside drainage bag. The DON said she would disconnect the tubing from the catheter and then clean the connection tubing with an alcohol pad before reconnecting the tubing to the catheter. She stated she was unsure why staff were reusing bags and that staff needed education. An interview was conducted on 04/18/24 01:07 PM with the Physician Assistant (PA). She stated staff should be getting a new urinary drainage bag each time. She explained there was a potential for introducing new infections if not using new clean equipment or cleaning the tubing before reconnecting the catheter. The PA said she was not aware that this was occurring An interview was performed on 4/18/24 at 1:48 PM with the Administrator. He stated used urinary drainage collection bags should be disposed of and not stored anywhere for reuse. He explained staff should not be reusing urinary catheter drainage bags and a new bag should be used each time. He stated if staff were reusing bags the tubing should have been cleaned prior to reconnecting it to the catheter. He stated he was unsure why staff were reusing catheter drainage bags. The Administrator stated reusing urinary drainage bags could introduce bacteria that could cause an infection.	F 690		
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	F 695		5/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 36 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 observations, record reviews, and staff and resident interviews, the facility failed to post precautionary and safety signs that indicated the use of oxygen for 2 of 2 residents reviewed for respiratory care (Resident #117 and Resident #5). The findings included: 1. Resident #117 was admitted to the facility on 03/18/24 with diagnoses that included unspecified diastolic (congestive) heart failure, shortness of breath, and acute respiratory failure with hypoxia. Review of Resident #117's physician orders dated 03/18/24 revealed an order for continuous oxygen delivered at 2 liters per minute via nasal cannula. A review of Resident #117's 5-day Minimum Data Set assessment dated 03/22/24 revealed Resident #117 was cognitively intact. She received continuous oxygen therapy for shortness of breath (SOB) with exertion, while sitting at rest, and when lying flat. Resident #117's care plan dated 04/01/24 revealed she was at risk of complications such as decreased oxygen saturation levels, hypoxia, and shortness of breath based on her diagnoses of congestive heart failure and acute respiratory failure with hypoxia. Interventions included assisting with activities of daily living and encouraging rest periods to help conserve	F 695	Peak Resources Cherryville acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Resident Affected The facility has been a Tobacco free facility since 2016. Signs indicating the facility is a Tobacco Free Property were posted at all entrances to the facility and across the property per Life Safety Regulations and facility policy. A no smoking, oxygen in use sign is posted at all facility entrances and wherever oxygen is stored in the facility. No resident was adversely affected by the alleged deficient practice. Systemic Changes The Administrator educated the Maintenance Department on 04/16/2024 regarding the requirements that a sign be posted at the entrance to the facility that the facility is Tobacco free, that there is a requirement that a sign be posted at all entrances to the facility that there is no smoking/oxygen in use, and there are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 37 energy, monitoring her oxygen saturation levels, and oxygen as ordered. An observation of Resident #117 on 04/15/24 at 10:07 AM revealed she was in her room, sitting in her wheelchair, and had completed her breakfast. Resident #117 was observed with oxygen being delivered at 2 liters per minute via nasal cannula. There were no precautionary or safety signs to indicate that oxygen was in use noted in Resident #117's room, on her door, or anywhere in her environment. A subsequent observation of Resident #117 on 04/16/24 at approximately 9:50 AM revealed Resident #117 sitting in her wheelchair, speaking with her visiting family. She received 2 liters of continuous oxygen per minute via nasal cannula. There were no precautionary or safety signs to indicate that oxygen was in use posted in her environment. An interview with NA #2 was conducted on 04/17/24 at 9:48 AM. She verbalized awareness of oxygen use by residents; and, reported that no oxygen use signage was posted outside of individual resident rooms. An interview with NA #3 was conducted on 04/17/24 at 10:02 AM. She verbalized awareness of oxygen use by Resident #117. NA #3 reported that no oxygen use signage was posted outside of individual resident rooms. An interview with Nurse #6 was conducted on 04/17/24 at 10:16 AM. She verbalized awareness of residents of the facility using oxygen; however, reported that no oxygen use signage was posted outside of individual resident rooms.	F 695	signs for no smoking/oxygen in use wherever oxygen is stored in the facility. In addition, no smoking/oxygen in use signs are placed outside resident rooms where oxygen is in use. Monitoring An audit tool was developed to monitor for compliance with the plan of correction. The audit includes the following: • Is there a sign posted at the entrance to the facility that there is oxygen in use? • Are there signs posted where oxygen is stored? • Are there signs posted outside resident rooms where oxygen is in use? The Administrator will conduct these audits monthly x 3 months to ensure compliance with the plan of correction. The Maintenance Director will ensure these signs are posted at all times while completing the preventative maintenance rounds. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee by the Administrator monthly x 3 months for review and further recommendations. Date of Completion: 05/08/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 38	F 695		

An interview with the Director of Nursing was conducted on 04/18/24 at 8:31 AM. She reported that the facility's oxygen in use signage was posted at the front door of the facility, which was their policy.

An interview with the Administrator was conducted on 04/18/24 at 8:48 AM. He stated that the corporate office informed him that oxygen in use signage posted at entrance doors covered the entire facility per the State regulations and the facility has been non-smoking since 2016.

2. Resident #5 was admitted to the facility on 3/3/2022 with diagnoses that included chronic respiratory failure and chronic obstructive pulmonary disease.

A review of the quarterly Minimum Data Set (MDS) dated 1/31/2024 indicated Resident #5 was moderately cognitively impaired and received oxygen therapy during the MDS assessment period.

A review of Resident #5's physician orders revealed an order for oxygen delivered via nasal cannula at 3 liters per minute (lpm) continuously.

An observation of Resident #5 was conducted on 04/15/2024 at 11:36 AM. Resident #5 was lying in bed wearing a nasal cannula with oxygen being delivered at 3 lpm. There was no cautionary or safety signage for the use of oxygen observed in Resident #5's room, outside her room or anywhere in her environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 39 Another observation of Resident #5 was conducted on 04/16/2024 at 9:00 AM. Resident #5 was lying in bed wearing a nasal cannula with oxygen being delivered at 3 lpm. There was no cautionary or safety signage observed in Resident #5's room, outside her room or anywhere in her environment. An interview was conducted with the Director of Nursing (DON) on 04/16/2024 3:45 PM. The DON stated safety signage for the use of oxygen and a no-smoking sign were posted on the door at the main entrance and visible to anyone that entered the building. The DON indicated cautionary or safety signage for oxygen in use was not posted outside, in or around the resident rooms because they were a non-smoking facility and the signage at the main entrance covered the entire facility. An interview was conducted with the Administrator on 04/17/2024 at 9:26 AM. He revealed there was a no smoking sign and safety signage for oxygen in use posted on the front door at the main entrance of the facility. The Administrator indicated because the facility was non-smoking and signage was posted at the main entrance, they did not post cautionary or safety signage outside, in or around resident rooms where oxygen was in use.	F 695		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		5/8/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 732	Continued From page 40 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to post the correct Skilled Nursing Facility census, the actual staff working hours, and change the staff posting each shift to reflect changes in actual working hours for	F 732	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 732	Continued From page 41 36 of 49 days reviewed for posted nurse staffing information. The findings included: A review of the posted nurse staffing information from March 2024 was conducted and revealed the following: - Posted nurse staffing information from 3/1/2024 revealed computer-generated staff postings, with a census of 117, and reflected the scheduled working hours of both the Skilled Nursing and Assisting Living nursing staff. - Posted nurse staffing information from 3/2/2024 was handwritten, with a census of 66, and reflected the actual working hours of staff. - Posted nurse staffing information from 3/3/2024 was handwritten, with a census of 67, and reflected the actual working hours of staff. - Posted nurse staffing information from 3/4/2024 through 3/8/2024 revealed computer-generated staff postings, with a census of 117, and reflected the scheduled working hours of both the Skilled Nursing and Assisting Living nursing staff. - Posted nurse staffing information from 3/9/2024 was handwritten, with a census of 66, and reflected the actual working hours of staff. - Posted nurse staffing information from 3/10/2024 was handwritten, with a census of 66, and reflected the actual working hours of staff. - Posted nurse staffing information from 3/11/2024 through 3/15/2024 revealed computer-generated staff postings, with a census of 117, and reflected the scheduled working hours of both the Skilled Nursing and Assisting Living nursing staff. - Posted nurse staffing information from 3/16/2024 and 3/17/2024 was handwritten, with a	F 732	requirements and to continue to provide high quality care. Resident affected and residents with potential to be affected The Administrator corrected and posted the daily staffing information on 4/18/24 to reflect correct skilled nursing census and correct skilled nursing staffing hours. The Administrator completed an audit of all posted daily staffing hours from 3/1/24 thru 4/18/24 to identify corrections to be made regarding posted daily “Nurse Staffing Information”. Any errors were corrected on that date. No resident suffered any adverse effects related to the alleged deficient practice. Systemic changes The Administrator was educated by the Corporate Compliance Manager on 05/08/2024 regarding the requirement for posting of the daily staffing hours to include the current census and direct care giver hours. The Administrator educated the staffing coordinator and Charge Nurses on 4/18/2024. This education included the posting of the daily nurse staffing information, including current census and direct caregiver hours. Staffing Coordinator will make changes throughout the day as they occur on weekdays. Charge Nurses for all shifts and weekends will make changes throughout their shifts as they occur for weeknights and weekend shifts and when the Staffing coordinator is out on leave .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 732	Continued From page 42 census of 64, and reflected the actual working hours of staff. - Posted nurse staffing information from 3/18/2024 through 3/22/2024 revealed computer-generated staff postings, with a census of 117, and reflected the scheduled working hours of both the Skilled Nursing and Assisting Living nursing staff. - Posted nurse staffing information from 3/23/2024 was handwritten, with a census of 62, and reflected the actual working hours of staff. - Posted nurse staffing information from 3/24/2024 was handwritten, with a census of 61, and reflected the actual working hours of staff. - Posted nurse staffing information from 3/25/2024 through 3/29/2024 revealed computer-generated staff postings, with a census of 117, and reflected the scheduled working hours of both the Skilled Nursing and Assisting Living nursing staff. - Posted nurse staffing information from 3/30/2024 was handwritten, no current census, and reflected the actual working hours of staff. - Posted nurse staffing information from 3/31/2024 was handwritten, with a census of 63, and reflected the actual working hours of staff. A review of posted nurse staffing information from April 2024 was conducted and revealed the following: - Posted nurse staffing information from 4/1/2024 through 4/5/2024 revealed computer-generated staff postings, with a census of 117, and reflected the scheduled working hours of both the Skilled Nursing and Assisting Living nursing staff. - Posted nurse staffing information from 4/6/2024 was handwritten, with a census of 67, and reflected the actual working hours of staff.	F 732	Monitoring Tool implemented to ensure the daily staffing posting is current and accurate. Monitoring Tool to be completed by the Director of Nursing three times weekly for 4 weeks, then 3x every 2 weeks x 4 weeks, then monthly x 1 month. Monitoring Tool to be presented by the Director of Nursing at the monthly Quality Assurance and Performance Improvement Committee meeting for 3 months to evaluate compliance and effectiveness. Completion Date: 05/08/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 732	Continued From page 43	F 732		

- Posted nurse staffing information from 4/7/2024 was handwritten, with a census of 67, and reflected the actual working hours of staff.
- Posted nurse staffing information from 4/8/2024 through 4/12/2024 revealed computer-generated staff postings, with a census of 117, and reflected the scheduled working hours of both the Skilled Nursing and Assisting Living nursing staff.
- Posted nurse staffing information from 4/13/2024 and 4/14/2024 were handwritten, with a census of 67, and reflected the actual working hours of staff.

An observation of posted nurse staffing information was conducted on 4/15/2024 at 10:04 am and revealed a census of 117 and combined staff working hours for both Assisted Living and Skilled Nursing units.

An observation of posted nurse staffing information was conducted on 4/16/2024 at 10:49 am and revealed a census of 117 and combined staff working hours for both Assisted Living and Skilled Nursing units.

An observation of posted nurse staffing information was conducted on 4/17/2024 at 8:19 am and revealed a census of 117 and combined staff working hours for both Assisted Living and Skilled Nursing units.

An observation of posted nurse staffing information was conducted on 4/18/2024 at 8:05 am and revealed a census of 117 and combined staff working hours for both Assisted Living and Skilled Nursing units.

An interview was conducted on 4/18/2024 at 9:45 am with the Director of Nursing (DON). The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 732	Continued From page 44	F 732		

stated the Scheduler was responsible for updating the posted nurse staffing information every morning. She reported the posted staffing information that was at the nurses' station was computer generated and reflected the number of Nurse Aides (NAs) and Nurses on the computer-based schedule and was printed one time in the morning. She stated the Scheduler would print the schedule for Saturdays and Sundays on Friday and leave it for the Charge Nurse to post. She reported the Charge Nurse was responsible for changing the posted nurse staffing information on the weekends. She was not aware that the census and actual staff working hours for both the Assisted Living and Skilled Facility units were reflected on the posted nurse staffing and verbalized the posting should have reflected the current census and actual working hours of staff for the Skilled Nursing units only. She reported the error had occurred because the filter was not set correctly and verbalized the posted staffing should have been changed every shift to reflect the actual working hours.

An interview was conducted on 4/18/2024 at 9:37 am with the Scheduler. The Scheduler stated she was responsible for posting the current nurse staffing information every morning except on the weekends. She reported when she got to work every morning, she would print the staffing sheet and post the updated information at the nurses' station. She stated she printed the staffing information for Saturday and Sunday on Friday before she left and would leave it for the Charge Nurse. She reported she was not aware the computer was pulling the census and staffing for both the Assisted Living and Skilled Nursing units and combining them on the form she printed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 732	Continued From page 45 She reported the Skilled Nursing unit only had 70 beds and the census for the Skilled Nursing unit alone should never have been 117. She reported the call outs are updated as they occur on the actual schedule and that she never reprinted the sheets to reflect the actual workings staff hours. An interview was conducted on 4/18/2024 at 10:42 am with the Administrator. The Administrator had been made aware by the DON the posted nurse staffing information had been incorrect He reported the posted nurse staffing should be changed daily and when changes occurred.	F 732		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761		5/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 761	Continued From page 46 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, manufacturer's recommendations, and staff interviews, the facility failed to date opened multi-dose insulin pens, failed to discard expired insulin pens and a multi-dose insulin vial, and failed to store a multi-dose insulin vial in the refrigerator for 2 of 2 insulin medication carts (Cherry Street cart and Mulberry Hall cart) reviewed for medication storage and labeling. The findings included: 1a. The manufacturer's storage instructions for Levemir insulin indicated to store in-use vials under refrigeration or at room temperature and use within 42 days. The manufacturer's storage instructions for Levemir insulin in-use prefilled pens indicated, the pens should be stored at room temperature and used within 42 days; do not freeze or refrigerate. The manufacturer's storage instructions for Lispro indicated to store prefilled pen in the refrigerator until it is opened, but do not freeze it, prefilled pen is in use and should be stored at room temperature for 28 days. The manufacturer's storage instructions for Glargine insulin indicated prefilled pens should be stored at room temperature and used within 28 days; do not freeze or refrigerate.	F 761	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. Affected resident All opened and undated, expired and smeared dated insulin pens were removed from the medication carts and disposed of immediately on 4/16/2024 and 4/17/2024 by the Director of Nursing (DON). Residents with potential to be affected All residents in the facility have the potential to be affected by the alleged deficient practice. The Director of Nursing (DON) and Staff Development Coordinator (SDC) checked all medication carts in the facility to ensure that there were no opened and undated, expired, or smeared dated insulin pens and vials in the medication cart on 4/17/2024. No additional opened and undated, expired, or smeared dated insulin pens or vials were observed in any cart in the facility. No resident was affected by the alleged deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 761	Continued From page 47 On 04/16/24 at 4:15 PM an observation of the insulin cart for Cherry Street Hall was conducted with Nurse #4. The observation revealed the following: -Levemir (is a long-acting insulin used to improve blood sugar control in people with diabetes mellitus) 100ml (milliliter) vial opened on 02/19/24 and placed in the insulin cart. The manufacturer's instructions stated to dispose 42 days after opening. -Levemir insulin pen opened and not dated. -Lispro insulin (is a fast-acting insulin used to lower levels of glucose (sugar) in the blood) pen opened on 03/07/24 and passed the manufacturer's instructed 28-day expiration date of 04/04/24. -Glargine insulin (is used to improve blood sugar control in people with diabetes mellitus.) pen opened and not dated. On 04/16/24 at 4:25 PM an interview was conducted with Nurse #4 who stated she did not realize some of the insulin pens were not dated and had expired. Nurse #4 stated she usually tried to check the insulin cart when she came in on her shift from 3:00PM to11:00PM. She continued to state she would make the Director of Nursing (DON) aware and discard the expired insulin pens immediately. 1b. On 04/17/24 at 9:13 AM an observation of the insulin cart for Mulberry Hall was conducted. The observation revealed: -NovoLog (fast-acting insulin used to lower levels of glucose (sugar) in the blood) insulin Flex pen opened, and the date was illegible. The ink was	F 761	Systemic Changes All licensed nurses and medication aides were educated on policy regarding proper labeling and storage of insulin pens and vials by the SDC, DON and/or their designee. This education was completed by 4/18/2024. Any licensed nursing staff or medication aide out on leave or PRN status will be educated prior to returning to duty by the Staff Development Coordinator. Newly hired licensed nursing staff and medication aides are educated on this process during orientation by the Staff Development Coordinator. Monitoring An audit tool was developed to ensure compliance with the plan of correction. The audit tool contains the following: 1. Are there any opened and undated, expired or smeared dated insulin pens or vials on the medication carts? The Director of Nursing/designee will audit 50% of all medication carts weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of the audits will determine the need for further monitoring. The DON will bring the results of these audits to the monthly Quality Assurance and Performance Improvement Committee meeting x 3 months for further review and recommendations. All corrective actions referenced in this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 761	Continued From page 48 smeared over the discard date, opened date incomplete, and unidentifiable. On 4/17/24 at 9:20 AM an interview was conducted with the Charge Nurse who stated she would discard the insulin pen (NovoLog Flex pen) and let the DON know. On 04/17/24 at 2:30 PM an interview was conducted with the DON. The DON stated the Charge Nurse and Nurse #4 had made her aware the insulin pens in the insulin carts had not been dated or stored properly. She stated she expected the nurses and medication technicians to be checking the insulin carts daily and each shift; as well as all insulin pens labeled when they were opened, stored correctly, and discarded 28 days after opening. She further stated the pharmacist who came in every month also checked the insulin and medication carts.	F 761	Plan of Correction (POC) will be in place by 5/6/2024.	
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to provide a dysphagia mechanical consistency meal as ordered by the nurse practitioner for 1 of 1 resident reviewed for nutrition (Resident #1). The findings included:	F 805	Filing the plan of correction does not constitute admission that the deficiencies alleged 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 of care.	4/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 805	Continued From page 49 Resident #1 was admitted to the facility on 11/20/23 with diagnoses which included history of traumatic brain injury, gastro-esophageal reflux disease without esophagitis, type 2 diabetes mellitus, and diaphragmatic hernia. A review of the Nurse Practitioner's diet order dated 11/20/23, indicated that Resident #1 was to receive a carbohydrate-controlled diet (CCD) with a dysphagia mechanical consistency (which required a change in the texture of food or liquids). A review of Resident #1's quarterly Minimum Data Set (MDS) dated 01/02/24 indicated that she was severely cognitively impaired, required setup or clean up assistance for eating, and received a mechanically altered diet (which required a change in texture of food or liquids) and a therapeutic diet. A continuous observation was completed of Resident #1 during meal service from 12:44 PM to 12:53 PM. An observation of Resident #1's dietary communication slip for lunch on 04/15/24 at 12:44 PM was for ground kielbasa sausage with brown gravy, pureed baked beans, pureed capri vegetable blend, pureed dinner roll, unsweet tea, and pureed cake. Instead, she received a whole pork chop, which was detected by Nursing Assistant (NA) #3. NA #3 returned the meal to the kitchen at 12:45 PM. Dietary Aide #3 delivered a second meal tray to Resident #1 at 12:49 PM which had ground kielbasa sausage with brown gravy, non-pureed baked beans, non-pureed capri vegetable blend, pureed dinner roll, unsweet tea, and pureed cake. Resident #1 proceeded to take 2-3 small bites of her meal from the tip of	F 805	Affected Resident Resident #1 was provided an appropriate meal tray on 04/15/2024 by the dietary department upon notification. Resident #1 did not experience any negative effect related to the alleged deficient practice. Other Residents with the potential to be affected The Dietary Manager confirmed that all other residents ordered a mechanically altered diet did receive the correct meal on 04/15/2024. No resident suffered any adverse effects related to the alleged deficient practice. Systemic Changes The Regional Dietary Manager educated all Dietary staff regarding tray line process specifically related to meal tray preparation and providing the accurate texture consistency for all resident meals. Education provided on 4/15/2024. Any dietary staff out on leave or PRN status will be educated on this process prior to returning to duty by the Dietary Manager/designee. All newly hired dietary staff are educated on this process by the Dietary Manager/designee during orientation. Monitoring An audit tool was developed to ensure that residents ordered mechanically altered diets receive the correct diet consistency for all meals. The Dietary Manager will audit 25% of residents with mechanically altered diets weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. These audits will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 805	Continued From page 50 her fork. NA #3 returned to check on Resident #1 at 12:53 PM and noticed the meal tray consistency was not correct. Again, NA #3 returned the meal to the kitchen and provided the prescribed meal to Resident #1. During an interview with NA #3 on 04/15/24 at 12:56PM, she stated Resident #1 received a pork chop, baked beans, and vegetable medley on her first tray, which NA #3 returned to the kitchen because Resident #1's mechanical pureed diet order did not include a fried pork chop in that form. Upon checking the second meal, NA #3 stated that she noticed that a tray with non-pureed vegetables had been delivered by Dietary Aide #3 and verbalized plans to return the tray to the kitchen. NA #3 reported that the residents' meals were normally prepared and delivered as prescribed and listed on the meal ticket. During an interview with Dietary Aide #3 on 04/15/24 at 1:02 PM, she stated that she delivered the wrong replacement meal to Resident #1. She reported that she was not working on the dietary line but did receive the first replacement meal, which she covered without double checking the dietary ticket for Resident #1. She stated that the process should have been for Dietary Aide #1 to provide the plate, beverages, and condiments as she read out the order to the Cook who placed the food on the plate. She reported that Dietary Aide #2 should have double checked to ensure that the ticket and the meal matched. An interview completed with Dietary Aide #1 on 04/15/24 at 1:27 PM revealed she was responsible for the meal tickets. Dietary Aide #1	F 805	completed on random meals throughout the day, including weekends. The audits will be brought to the monthly Quality Assurance and Performance Improvement Committee by the Dietary Manager for 3 months. The Monitoring Tool will be reviewed by the QAPI Committee to ensure compliance and evaluate effectiveness. Completion date: 4/18/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 805	Continued From page 51	F 805		

explained she called out the diet to the cook, and placed the condiments, desserts, and silverware on the resident meal trays. Then she slid the resident meal tray down the line to Dietary Aide #2.

An interview with the Cook on 04/15/24 at 1:09 PM revealed that Dietary Aide #1 hollered for a pork chop with noodles, capri blend, and a roll. She stated that the meal given to Resident #1 was a different ticket for a different resident's tray. She reported that the process should have been Dietary Aide #1 calling out the diet to the Cook who prepared the plates. She stated Dietary Aide #2 was responsible for rechecking the ticket and that Dietary Aide #1 had requested a mechanical diet for Resident #1.

During an interview with Dietary Aide #2 on 04/15/24 at 1:13 PM, she reported that the mechanically altered ticket for Resident #1 did have a pork chop on the plate. She explained she understood the difference between diet types and verbalized she verified the diet ordered versus what was on the meal ticket. Dietary Aide #2 was uncertain as to why Resident #1 received the wrong meal tray two times.

An interview with the Dietary Manager on 04/15/24 at 1:17 PM revealed that the process for meal plating should have been for Dietary Aide #1 to have placed the condiments and utensils on the tray, then she should have read out the ticket to the Cook, who prepared the plate. Afterwards, the Dietary Aide #1 should have slid the tray to Dietary Aide #2 for placement of the beverages and any supplements The Dietary Manager stated Resident #1 should have received the right plate the first time. Dietary Aide #2 should have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 805	Continued From page 52	F 805		

verified the correct meal type prior to the meal tray leaving the kitchen.

An interview with the District Dietary Manager on 04/15/24 at 1:23 PM revealed that Dietary Aide #2 should have confirmed that the plate was for Resident #1's meal ticket. She stated that she believed that Dietary Aide #2 just "grabbed" the wrong plate because the proper diet for Resident #1 was prepared and available.

An interview with the Registered Dietician on 04/16/24 at 12:34 pm revealed that dietary staff was trained upon hire then staff received various computer-based in-services which are rotated monthly, depending upon each staff member's date of hire. She shared that all other residents that received pureed diets on 04/15/24 - except Resident #1 - received the proper meals. She stated all dietary staff were to follow the tray ticket and serve what was on the ticket. She reported that the aides on the dietary line either misread the ticket, grabbed the wrong food item, or didn't hear the ticket being read off. She reported that the last Dietary Aide (#2) on the line should have double-checked the plate before putting a lid on it.

An interview with the Director of Nursing on 04/18/24, who was aware that Resident #1 received the wrong meals twice on 04/15/24, revealed that the dietary staff should have checked trays/meals before the meals left the kitchen, and that NAs and staff should have verified that tickets and meals matched before they delivered the meals to residents.

During an interview with the Administrator on 04/18/24 at 8:47 am, he stated that the current

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 805	Continued From page 53 process worked well because NA #3 detected the discrepancy in the meals and the prescribed diet.	F 805		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to honor food choices for 2 of 2 sampled residents (Residents #38 and # 27) reviewed for preferences. The findings included: 1. Resident # 38 was re-admitted to the facility on 7/6/22. The most recent Quarterly Minimum Data Set (MDS) assessment dated 2/7/24 revealed that Resident #38 was cognitively intact and did not receive a therapeutic or mechanically altered diet. An interview and observation was conducted with Resident # 38 on 4/16/24 at 8:30 AM. She was in her room and had her breakfast tray set up in front of her on the overbed table and was drinking coffee. Her meal plate had uneaten scrambled	F 806	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. Affected resident On 4/15/2024 and 4/16/2024 with resident #27 and 4/16/2024 and 4/17/2024 with resident #38 it was revealed in an interview and observation during breakfast with residents #27 and #38 that there were no likes/dislikes listed on their tray cards, however they both stated they had expressed dislikes that were served for breakfast on those days. The Dietary Manager interviewed both residents to obtain preferences and corrected the	5/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 54 eggs and dark toast on it. She stated she had only eaten the oatmeal off her breakfast tray. Resident #38 stated the other foods on her breakfast tray were foods she did not like. She stated she did not like and does not eat "powdered eggs" and the toast was too hard to eat. She did not say if she had asked for anything else for breakfast. An interview and observation was conducted with Resident #38 on 4/17/24 at 8:20 AM. She was sitting up on the side of her bed with her breakfast tray sitting in front of her on the bedside table. Her breakfast tray included scrambled "powdered eggs", dark toast with blacking along the edges, milk, cold cereal, oatmeal, biscuit with sausage gravy, orange juice, butter, jelly sugar packets, and coffee. Resident #38 was eating the biscuit and gravy. She stated she would only eat the biscuit and gravy off her breakfast tray. Resident #38 stated again, she disliked and would not eat the scrambled "powdered eggs" on her plate or the hard toast. She stated the toast was hard everyday and they served her the eggs every day. Resident #38 stated she had spoken to someone in the past from the kitchen and had told them she did not like the "powdered eggs". She stated the person she had talked to from dietary no longer worked at the facility and that it had been over a year since anyone from dietary had talked to her about her food likes and dislikes. She did not say if she had asked to speak to someone in dietary over the last year. On 4/17/24 Resident #38's breakfast dietary meal tray card was reviewed and revealed she had a regular diet ordered. There were no food preference likes/ dislikes listed on the meal tray card. The bottom of the meal tray card stated,	F 806	meal cards on 4/17/2024. Residents with potential to be affected All residents have the potential to be affected by the alleged deficient practice. No resident suffered any adverse effect related to the alleged deficient practice. An Audit of all residents was completed to identify residents with food preferences. All residents with food preferences were identified and these preferences were documented on the meal tickets. This was completed by the Dietary Manager on 04/17/2024 to ensure residents were receiving meals according to their food preferences. No other issues were noted. Systemic changes On 4/16/2024, the District Operations Manager with Healthcare Services Group educated the Dietary Manager on the correct process for obtaining food preferences, ensuring food preferences are indicated on the meal tickets and ensuring that residents are receiving meals according to their preferences. Monitoring An audit tool was developed to ensure that meal preferences are obtained, listed on the meal tickets and meals are served according to resident preferences. The Dietary manager/Designee will audit 10 random meal trays per week during the week and weekends X 4 weeks, then every other week X 4 weeks, then monthly X 1 month to ensure compliance. The results of these audits will be brought to the Quality Assurance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 55 "eggs instead of hashbrowns". An interview was conducted on 4/16/24 at 11:45 AM with the Director of Nursing (DON). She provided a printed form titled "food preference assessment" for Resident #38. The date listed at the top of the assessment was 4/16/24. The DON stated the assessment had been printed from "meal tracker" [meal tracker is the dietary system used for menu planning and that prints the meal tray card tickets]. She stated 4/16/24 was the date the assessment was printed from "meal tracker". She stated 4/16/24 was not the date the assessment had been completed but could not provide the exact date the likes/dislikes information had been documented into "meal tracker". There was no documentation on the assessment form as to who had completed or entered the information. The food preference assessment for Resident #38 did not list scrambled eggs or toast as dislikes. Review of "meal tracker" activity log revealed Resident #38's likes/ dislikes had last been updated on 9/10/20. An interview was conducted on 4/17/24 at 9:50 AM with the Registered Dietician (RD). She stated the Dietary Manager completed food preference likes/ dislikes for residents when they were admitted and then quarterly with reviews. She stated the Dietary Manager updated the resident's food likes/ dislikes in meal tracker. An interview was conducted on 4/17/24 at 10:40 AM with the Dietary Manager. She stated she had been the Dietary Manager for about a year and had not really received a lot of training on paperwork or the computer part of her job. She stated she had not known that she had to fill out a	F 806	Performance Improvement Committee monthly x 3 months by the Dietary Manager for review and further recommendations. All corrective actions referenced in this Plan of Correction (POC) will be in place by 5/6/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 56	F 806		

dietary preference form for resident food likes/ dislikes or put the information into the meal tracker computer system until about 2 months ago. The Dietary Manager stated she would see a resident and ask them their food likes/ dislikes and then put the information into meal tracker. She stated meal tracker would remove the disliked food item from the resident's profile as a food option and the disliked food would not appear on the resident's meal tray card ticket. She stated meal tracker was where the meal tray card/ tickets were printed from. The Dietary Manager stated she now would see residents within a few days of their admission and completed a foods preference likes/ dislikes form. She stated she had started the process of updating and completing the food preference likes/ dislikes form for all current and new residents when she had been made aware 2 months ago of the food preference likes/ dislikes form she was supposed to be using. She stated the facility's scrambled eggs were liquid eggs not powdered eggs. She stated fresh eggs were available if a resident preferred fried eggs, hard boiled eggs, or did not like the liquid scrambled eggs. She stated unless she removed grits as an option on a resident meal ticket profile in meal tracker the printed meal tray card/ ticket would just say "hot cereal". She stated the meal tray card/ ticket contained the resident's diet, food allergies, and food items to be included on the meal tray. She stated that dietary staff plating food could only see what was printed on the meal tray card/ticket and would not know if a resident disliked a food. She stated the bottom of the meal ticket would say "eggs instead of hashbrowns" or "rice instead of potatoes" if dietary was out of an item. She stated if they were out of an item, or the item did not come in on the food truck order she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 57	F 806		

had to substitute the food item for something else, such as substituting a starch for another starch. She could not say how staff would know if a resident disliked a substituted food item such as eggs if "eggs instead of hashbrowns" was printed on the bottom of the meal tray card/ ticket. She stated the system allowed her to use the "note pad" in meal tracker to put in a disliked food and this would be visible on a resident's meal tray card/ticket but stated she had not done this routinely. The Dietary Manager stated she had not been aware of the dietary preference assessment form for Resident #38 until yesterday 4/16/24. She stated the form had been printed out and given to her yesterday by the RD. The Dietary Manager stated she had not seen Resident #38 to complete the new dietary food preference likes/ dislikes form with her.

An interview was conducted on 04/17/24 at 11:40 AM with Nurse Aide (NA) #4. She stated how meal trays were delivered to residents who dined in their rooms. She stated dietary brought the tray cart to the hallway, then nursing staff passed out the meal trays according to room numbers. NA #4 stated each tray had a tray meal card/ ticket that had the residents name on it, their diet, food allergies, and what food, drinks, and condiments were supposed to be on the tray. She stated when she delivered a meal tray, she helped set up the tray and checked to make sure the diet and food items on the tray matched what was on the tray meal card/ ticket. She stated if a resident told her they did not like something she would ask them if they wanted something else as a substitute. She stated she thought some tray meal card/tickets had "dislikes" listed at the top of the ticket with allergies but was not sure. She was not sure how she would know if a resident who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 58	F 806		

was not oriented would like or dislike a food item served on their meal tray.

An interview was conducted on 4/17/24 at 3:46 PM with the Administrator. He stated food likes/ dislikes should be done by the Dietary Manager within 72 hours after admission and should then be entered into meal tracker. He stated after admission dietary preference food likes/ dislikes should be done quarterly and updated as needed. The Administrator stated he could not say what happened in the process where dietary was not completing food preference likes/ dislikes.

2. Resident #27 was admitted to the facility on 10/5/23.

The most recent Quarterly Minimum Data Set (MDS) assessment dated 2/17/24 revealed that Resident #27 was cognitively intact and received a mechanically altered therapeutic diet.

An interview was conducted on 4/15/24 at 10:52 AM with Resident # 27. She stated she did not like to eat grits or "powdered" eggs. She stated she received these items on her meal tray often. She stated she had spoken with someone from the kitchen about her food likes and dislikes but was unsure who the person was or when she had spoken to them.

An interview and observation were conducted on 4/16/24 at 8:40 AM with Resident #27. She was sitting up in her bed drinking coffee with her breakfast tray set up in front of her on her overbed table. She had grits and toast on her plate that were uneaten. When asked how breakfast was, she stated, "look for yourself" "I

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 59	F 806		

don't eat grits and I've told them I don't eat grits". She again stated she had spoken to someone from dietary in the past and told them she did not like grits but could not remember who she had spoken to. She did not say if she had asked for anything else for breakfast.

A second observation was conducted on 4/17/24 at 8:15 AM of Resident #27 sitting up in bed with her breakfast tray set up in front of her on her overbed table. Her breakfast tray included oatmeal, "powdered" scrambled eggs, and coffee.

Resident #27's dietary meal tray card was reviewed for breakfast, lunch, and dinner on 4/16/24 and for breakfast on 4/17/24. The meal tray card revealed she was on a consistent carbohydrate diet (CCD). There were no food preference likes/ dislikes listed on the meal tray card. The breakfast meal tray card for breakfast on 4/17/24 stated at the bottom "eggs instead of hashbrowns".

An interview was conducted on 4/16/24 at 11:45 AM with the DON. She provided a printed form titled "food preference assessment" for Resident #27. The date listed at the top of the assessment was 4/16/24. The DON stated the assessment had been printed from "meal tracker" [meal tracker is the dietary system used for menu planning and that prints the meal tray card tickets]. She stated 4/16/24 was the date the assessment was printed from "meal tracker". She stated 4/16/24 was not the date the assessment had been completed but could not provide the exact date the likes/dislikes information had been documented into "meal tracker". There was no documentation on the assessment form as to who had completed or entered the information.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 60	F 806		

The food preference assessment for Resident # 27 listed grits and scrambled eggs as dislikes. Review of the "meal tracker" activity log revealed Resident # 27 dislike for scrambled eggs and grits had been entered last on 11/30/23.

An interview was conducted on 4/17/24 at 9:50 AM with the Registered Dietician (RD). She stated the Dietary Manager completed food preference likes/ dislikes for residents when they were admitted and then quarterly with reviews. She stated the Dietary Manager updated the resident's food likes/ dislikes in meal tracker.

An interview was conducted on 4/17/24 at 10:40 AM with the Dietary Manager. She stated she had been the Dietary Manager for about a year and had not really received a lot of training on paperwork or the computer part of her job. She stated she had not known that she had to fill out a dietary preference form for resident food likes/ dislikes or put the information into the meal tracker computer system until about 2 months ago. The Dietary Manager stated she would see a resident and ask them their food likes/ dislikes and then put the information into meal tracker. She stated meal tracker would remove the disliked food item from the resident's profile as a food option and the disliked food would not appear on the resident's meal tray card ticket. She stated meal tracker was where the meal tray card/ tickets were printed from. The Dietary Manager stated she now would see residents within a few days of their admission and completed a foods preference likes/ dislikes form. She stated she had started the process of updating and completing the food preference likes/ dislikes form for all current and new residents when she had been made aware 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 61	F 806		

months ago of the food preference likes/ dislikes form she was supposed to be using. She stated the facility's scrambled eggs were liquid eggs not powdered eggs. She stated fresh eggs were available if a resident preferred fried eggs, hard boiled eggs, or did not like the liquid scrambled eggs. She stated unless she removed grits as an option on a resident meal ticket profile in meal tracker the printed meal tray card/ ticket would just say "hot cereal". She stated the meal tray card/ ticket contained the resident's diet, food allergies, and food items to be included on the meal tray. She stated that dietary staff plating food could only see what was printed on the meal tray card/ticket and would not know if a resident disliked a food. She stated the bottom of the meal ticket would say "eggs instead of hashbrowns" or "rice instead of potatoes" if dietary was out of an item. She stated if they were out of an item, or the item did not come in on the food truck order she had to substitute the food item for something else, such as substituting a starch for another starch. She could not say how staff would know if a resident disliked a substituted food item such as eggs if "eggs instead of hashbrowns" was printed on the bottom of the meal tray card/ ticket. She stated the system allowed her to use the "note pad" in meal tracker to put in a disliked food and this would be visible on a resident's meal tray card/ticket but stated she had not done this routinely. The Dietary Manager stated she had not been aware of the dietary preference assessment forms for Resident #27 until yesterday 4/16/24. She stated the forms had been printed out and given to her yesterday by the RD. The Dietary Manager stated she had not seen Resident #27 to complete the new dietary food preference likes/ dislikes form her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 62 An interview was conducted on 04/17/24 at 11:40 AM with Nurse Aide (NA) #4. She stated how meal trays were delivered to residents who dined in their rooms. She stated dietary brought the tray cart to the hallway, then nursing staff passed out the meal trays according to room numbers. NA #4 stated each tray had a tray meal card/ ticket that had the residents name on it, their diet, food allergies, and what food, drinks, and condiments were supposed to be on the tray. She stated when she delivered a meal tray, she helped set up the tray and checked to make sure the diet and food items on the tray matched what was on the tray meal card/ ticket. She stated if a resident told her they did not like something she would ask them if they wanted something else as a substitute. She stated she thought some tray meal card/tickets had "dislikes" listed at the top of the ticket with allergies but was not sure. She was not sure how she would know if a resident who was not oriented would like or dislike a food item served on their meal tray. An interview was conducted on 4/17/24 at 3:46 PM with the Administrator. He stated food likes/ dislikes should be done by the Dietary Manager within 72 hours after admission and should then be entered into meal tracker. He stated after admission dietary preference food likes/ dislikes should be done quarterly and updated as needed. The Administrator stated he could not say what happened in the process where dietary was not completing food preference likes/ dislikes.	F 806		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 806	Continued From page 63	F 806		
F 812 SS=E	. Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure bowls, plates, metal bowls, serving pans, and baking sheets were dry before they were stacked, and to ensure dishes were clean. These practices had the potential to affect food served to residents. The findings included:	F 812	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply wit the requirements and to continue to provide high quality of care.	4/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 812	Continued From page 64 a. The initial observation of the kitchen was conducted with the Dietary Manager (DM) on 4/15/2024 at 9:58 AM. The initial observation of the serving line and dish washing area revealed the following: - 12 plates stacked in a plate warmer on the serving line were wet. - 1 large serving pan, 2 baking sheets and 1 large metal bowl stacked on a storage rack in the dish washing area were wet. - 12 small red saucer plates with white crumb like particles and 1 small white saucer plate with a dried yellow substance were observed stacked on the storage rack for clean dishes in the dish washing area. b. A second observation of the serving line in the kitchen was conducted with the DM on 4/17/2024 at 11:45 AM and revealed the following: - 11 small white bowls stacked on the serving line were wet. An interview was conducted with the DM on 4/17/2024 at 2:25 PM. The DM indicated dishes and pans were washed in a low temperature dishwasher and placed on racks to dry. The DM revealed plates, bowls and pans should not be stacked while they were still wet. She indicated the dish washing area was humid and they had difficulty drying the dishes and pans before they were needed for the next meal service. The DM stated a fan was ordered and would be installed near the drying rack to ensure dishes and pans were dry before they were stacked and used for	F 812	All identified bowls, plates, metal bowls, serving pans and baking sheets were removed, rewashed and dried by the Dietary Manager to ensure cleanliness and proper drying method. This was completed on 04/15/2024. All residents have the potential to be affected by the alleged deficient practice. On 4/19/2024, the Regional Director of Dietary Services checked other sanitation processes in the kitchen and no other deficient practices were found. All dishes, pans, plates, bowls, saucers were observed clean, dry, and stored appropriately. Education provided to Dietary Staff by the Regional Director of Dietary Services related to the process of drying dishes and cookware prior to stacking and storage. The education provided was specifically related to not stacking wet dishes/wet cookware and ensuring cleanliness of dishes and cookware prior to use. The education was provided on 4/16/2024. Any dietary staff out on leave or PRN status will be educated prior to returning to duty by the Dietary Manager. Newly hired Dietary staff are educated on this process by the Dietary Manager/designee during orientation. Monitoring Tool implemented to ensure cleanliness of dishes and cookware prior to use; and to ensure dishes and cookware are not stacked wet. Monitoring Tool will be completed by the Dietary Manager three times weekly for 12 weeks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 812	Continued From page 65 the next meal. She stated staff checked the dishes when removing them from the dishwasher to ensure they were clean and items that were not clean were washed again. The DM further stated she was not able to explain why there were dirty dishes on the clean dish rack and staff should have noticed they were dirty and washed them again. An interview conducted with Dietary Aide #3 on 4/18/2024 at 9:45 AM revealed the dish washing process included spraying the dirty dishes with a degreaser, rinsing them, placing them in soapy water to soak, rinsing them again and then placing them in the dishwasher. She stated when dishes were removed from the dishwasher staff checked them to ensure they were clean. She indicated dishes that were not clean went through the washing process again. Dietary Aide #3 revealed the dirty dishes found on the clean dish rack 4/15/2024 was due to staff not checking them when they removed them from the dishwasher the previous day. Dietary Aide #3 stated due to the humidity in the dish washing area it was difficult for dishes and pans to dry before they were needed for the next meal service. She further stated wet dishes and pans should not be stacked. An interview was conducted with the Administrator on 4/18/2024 at 1:46 PM. He stated the facility used a low temperature dishwasher and dishes removed from the dishwasher had to be placed on a rack to dry. He indicated the dish washing room was humid which made the drying process more difficult, but a fan was ordered and would be installed in the dish washing area to help dishes and pans dry more quickly. He stated dishes and pans that	F 812	Monitoring Tool to be presented by the Dietary Manager at the monthly Quality Assurance and Performance Improvement Committee Meeting for 3 months. The QAPI Committee will review the monitoring tools to ensure compliance and evaluate effectiveness. All corrective actions referenced in this Plan of Correction (POC) will be in place by 4/18/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 812	Continued From page 66 were wet should not be stacked. The Administrator revealed dietary staff should be checking dishes when removing them from the dishwasher to ensure they were clean. He indicated dishes removed from the dishwasher that were still dirty should be washed again.	F 812		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance	F 842		5/6/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 842	Continued From page 67 with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to ensure accurate medical records when a resident's	F 842	This plan of correction constitutes our written allegation of compliance for the deficiency cited. However, submission of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 842	Continued From page 68 compression stockings were incorrectly documented as applied for 1 of 1 resident (Resident #220) reviewed for medical record accuracy. The findings included: Resident #220 was admitted to the facility on 3/11/2024. An admission Minimum Data Set (MDS) dated 3/15/2024 revealed Resident #220 was cognitively intact. A review of Resident #220's physician orders revealed an order dated 4/5/2024 to apply compression stockings to bilateral lower extremities upon rising and to remove at night before bed. A review conducted on 04/15/2024 at 3:22 pm of Resident #220's Medication Administration Record (MAR) of April 2024 for the period of 4/1/2024 through 04/18/2024 revealed Medication Aide (MA) #1 documented she had applied Resident #220's compression stockings on 4/15/2024. An interview and observation were conducted on 4/15/2024 at 3:18 pm of and with Resident #220. She was observed to not have compression stockings on her bilateral lower extremities during the interview and reported staff had not put compression stockings on her that morning (4/15/24). MA #1 was unavailable for interview. A review conducted on 04/15/2024 at 3:22 pm of	F 842	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. Affected resident On 4/17/2024 Nurse #1 applied Resident #220's compression stockings. This was confirmed during rounds on 4/17/2024 by The Director of Nursing (DON) as well. Nurse #2 and Med Aide #1 were educated by The Staff Development Coordinator (SDC) on ensuring that tasks documented as completed are completed as ordered on 4/17/2024. Resident #220 did not suffer any adverse effects related to the alleged deficient practice. Residents with potential to be affected All residents have the potential to be affected by the alleged deficient practice. On 4/17/2024 The Director of Nursing (DON) completed audit on all residents with orders for compression stockings to ensure placement and accurate documentation in the medical record. There were no additional instances of inaccurate documentation identified in any resident's medical record. No resident suffered any adverse effect related to the alleged deficient practice. Systemic changes On 5/6/2024, the Staff Development Coordinator educated all Licensed Nurses and Medication Aides on ensuring that tasks documented as completed are completed as ordered. Any licensed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 842	Continued From page 69 Resident #220's Medication Administration Record (MAR) of April 2024 for the period of 4/1/2024 through 04/18/2024 revealed Nurse #2 documented she had applied Resident #220's compression stockings on 4/16/2024. An interview and observation were conducted on 4/16/2024 at 11:32 am with Resident #220. She reported staff had not put her compression stockings on that morning (4/16/2024) and had told her that they could not find her compression stockings. Resident #220 also stated staff had told her they did not have compression socks to replace hers at that time. An empty extra, extra-large (XXL) compression stocking wrapper was observed on her nightstand beside her bed. She reported she always told staff to put them in her top nightstand drawer when they took them off, but the staff had not done that, and that they were no longer there. She proceeded to open her top nightstand drawer, which did not contain compression stockings. An interview and observation were conducted on 4/16/2024 at 11:38 am with Nurse #1. Nurse #1 reported compression stockings were ordered for Resident #220 to be applied daily. She reported that the third shift (11 pm to 7 am) was responsible for applying compression stockings when they had gotten the resident up in the morning. She verified that Nurse #2 had documented applying the compression stockings at 6:33 am on 4/16/2024. Nurse #1 walked to Resident #220's room, made an observation of the resident, and verbalized Resident #220 was not wearing compression stockings. She reported if it was charted, she would have expected them to be on Resident #220, and reported the Nurse should not have documented	F 842	nurse out on leave or PRN status will be educated prior to returning to duty by the SDC/designee. Newly hired licensed nursing staff and medication aides are educated on proper documentation of medication/treatment administration during orientation by the SDC/designee. Monitoring An audit tool was developed to monitor the medical record to ensure accurate documentation of placement of compression stockings. The Director of Nursing (DON) will observe the placement and documentation of compression stockings for 25 percent of residents weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will be brought to the Quality Assurance and Performance Improvement Committee monthly x 3 months by the DON for review and further recommendations. All corrective actions referenced in this Plan of Correction (POC) will be in place by 5/6/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 842	Continued From page 70	F 842		

application of compression stockings if the task had not been completed.

A phone interview was conducted on 4/18/2024 at 9:02 am with Nurse #2. Nurse #2 reported she worked third shift (from 11:00 pm on 4/15/2024 to 7:00 am on 4/16/2024) verbalized she had documented applying Resident #220's compression stockings. She stated that she had not put the compression stockings on Resident #220, and had asked a Nurse Aide (NA), whose name she was not able to recall, to put them on the resident. She reported she had not checked to ensure the NA had placed them on the resident because she was "busy" and "it happens." She reported the task should not have been charted as completed if the compression stockings had not been applied and the error occurred because she had not verified the NA had put them on.

An interview was conducted on 4/18/2024 with the Director of Nursing (DON). The DON stated application of compression stockings were typically documented on the Electronic Medical Record (EMR). She reported tasks documented as completed by staff were expected to have been completed.

An interview was conducted on 4/18/2024 at 10:41 am with the Administrator. He was not aware that Nurse #2 had documented application of compression stockings and had not applied them.

An interview was conducted on 4/18/2024 at 11:30 am with the Physician's Assistant (PA). She was not aware that MA #1 and Nurse #2 had documented the application of compression stockings without having applied them. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 842	Continued From page 71 reported if a task was documented as done, she would expect that it had been completed.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate,	F 867		5/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 867	Continued From page 72	F 867		

analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 867	Continued From page 73 activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the	F 867	This plan of correction constitutes our	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 867	Continued From page 74 facility's Quality Assessment and Assurance (QAA) committee failed to maintain implemented procedures and monitor interventions the committee had put into place following the recertification survey and complaint investigation completed on 10/19/2022. This failure included two repeat deficiencies in the areas of Notification of Changes (F580) and Respiratory Services (F695). Additionally, the facility's QAA committee failed to maintain implemented procedures and monitor interventions the committee had put into place following the recertification survey and complaint investigation completed on 8/20/2021. The failure included two repeat deficiencies that were originally cited in the areas of Label/ Store Drugs & Biologicals (F761), and Resident Allergies/ Preferences/ Substitutes (F806). All of the above areas were subsequently recited on the current recertification survey completed on 4/18/2024. The repeat deficiencies during three federal surveys of record showed a pattern of the facility's inability to sustain an effective QA program. The findings included: This citation is cross referred to: F580: Based on record review, staff and Physician Assistant interviews the facility failed to notify the physician of low blood pressures that required blood pressure medication to be withheld for 1 of 1 sampled resident reviewed for physician notification (Resident #27). During the recertification survey and complaint investigation of 10/19/2022 the facility failed to notify the responsible party after a resident was transferred to the hospital for 1 of 3 residents	F 867	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. The Administrator was educated by the Corporate Compliance Manager regarding the purpose of the Quality Assurance and Performance Improvement (QAPI) Program. The education included the objectives of the QAPI program including to identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan as needed, the purpose of the QAPI program to provide a means for resident care and safety issues to be resolved, and how the committee monitors issues and follows up with unresolved issues that have been identified. This was completed on 05/08/2024. Facility QAPI committee members will then be in-serviced by 05/09/2024 by the Administrator on the following: o The purpose of the QAPI Program o QAPI Committee is responsible for identifying and reviewing issues from past surveys and evaluating the current plan for its effectiveness and changing the plan, as necessary. o How the QAPI Committee monitors issues and follows up with unresolved issues that have been identified. QAPI committee members include the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 867	Continued From page 75 reviewed for notification. F695: Based on observations, record reviews, and staff and resident interviews, the facility failed to post precautionary and safety signs that indicated the use of oxygen for 2 of 2 residents reviewed for respiratory care (Resident #117 and Resident #5). During the recertification survey and complaint investigation of 10/19/2022 the facility failed to administer oxygen as prescribed by the physician for 3 of 3 residents reviewed for oxygen therapy. F761: Based on observations, manufacturer's recommendations, and staff interviews, the facility failed to date opened multi-dose insulin pens, failed to discard expired insulin pens and a multi-dose insulin vial, and failed to store a multi-dose insulin vial in the refrigerator for 2 of 2 insulin medication carts (Cherry Street cart and Mulberry Hall cart) reviewed for medication storage and labeling. During the recertification survey and complaint investigation of 8/20/2021 the facility failed to discard expired medications in 2 of 3 medication carts (600 Hall and 700 Hall) and failed to ensure the medication storage room was locked for 1 of 1 medication storage rooms (600 Hall) reviewed for medication storage. F806: Based on observations, record review, resident and staff interviews, the facility failed to honor food choices for 2 of 2 sampled residents (Residents #38 and # 27) reviewed for preferences. During the recertification survey and complaint	F 867	Medical Director, Pharmacy Consultant, Administrator, Director of Nursing, Minimum Data Set (MDS) nurses, Admission Coordinator, Social Worker, Business Office Manager, Staff Development Coordinator, Nursing Supervisor, Medical Records Manager, Maintenance Director, Housekeeping Supervisor, Dietary Manager, Treatment Nurse and Activities Director. An audit tool will be utilized to audit for compliance with the plan of correction. The Audit tool consists of the following: o Does the QAPI committee have a current plan and plans of correction in place? o Does the committee identify who is responsible for overseeing the plans? o Are the audits being completed as scheduled? o Are the plans working? o If not working, have changes been put in place to improve? This tool will be used by a QAPI sub-committee to establish the success of the QAPI projects and make recommendations as necessary. The sub-committee is made up of 3 members of the QAPI general Committee which will include the Director of Nursing, Staff Development Coordinator and the Administrator. The tool will be utilized monthly for 3 months. The results of the tool will be brought to the QAPI meeting monthly by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	04/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 867	Continued From page 76 investigation of 8/20/2021 the facility failed to honor food preferences for 1 of 1 resident reviewed for food preferences. An interview with the Administrator was conducted on 4/18/2024 at 3:30 PM revealed he had been in the position since December 2023. The Administrator explained he was in the process of improving the systems related to QAPI and follow-up of the Plan of Correction (POC) post survey. The Administrator verbalized the QAPI/Quality Assurance (QA) Manual was on-line and the documentation was available at any time for review. He voiced that improvement in performance was ongoing for better outcomes. The Administrator expressed it was his responsibility to make sure process and follow-ups continued and that planned outcomes were met.	F 867	Administrator and reviewed by the QAPI team. Completion date: 05/09/2024	