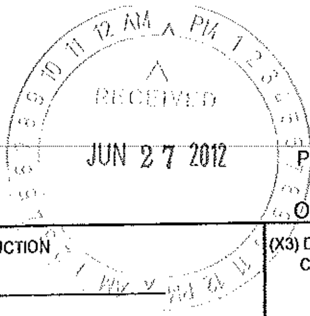

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING ______ B. WING ______	C 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to provide 4 residents (residents #64, #77, #114, and #50) with a dignified dining experience as evidenced by staff standing over four residents while feeding the residents in 2 of 2 dining areas (Restorative and main dining rooms) and leaving 1 resident (resident #104) unattended in the restorative dining room behind the meal tray transport cart at the end of the room while other residents were eating and/or being fed. Findings Include: 1. Resident # 104's medical record indicated the resident had diagnoses which included advanced Dementia, Parkinson's disease (End stage), and Adult Failure to Thrive. A review of the resident's Care Plan dated 05/07/2012 revealed the resident had Activities of Daily Living (ADL) which included, "At risk for weight loss/dehydration." The resident's Care Plan Interventions included, "Encourage oral intake of foods and fluids, Monitor and record food/fluid intake, Notify physician and family of significant weight change. The resident's annual MDS dated 03/15/12 documented the resident as being, "Severely cognitively impairment and able to eat	F 241	Filing the Plan of Correction does not constitute an admission that the deficiencies alleged did in fact exist. This 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. Residents 104, 64, 77, 50 and 114 were all assessed by the DON for any issues that may have been a result of findings of surveyor's observations. No resident was found to be affected as a result of the dining experience that was observed by the surveyor.	6/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bernard Bait — TITLE: Administrator — (X6) DATE: 6/25/12

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

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F 241	Continued From page 1 independently with set up only. A review of the resident's ADL Flow Sheet for May 2012 indicated the resident needed assistance with meals. A review of the resident's restorative feeding program notes (May 2012) indicated the resident ate on average of 25% of each meal and needed verbal cueing during dining as the resident had lost 13.57 pounds in the ninety days preceding 05/14/2012. On 06/05/2012 at 12:15 p.m., a continuous observation of resident # 104 was made where she was observed seated in her wheelchair at the end of the restorative dining room behind the food tray transport cart out of view of NA #2 and away from the table where her untouched lunch meal was observed already uncovered for more than 10 minutes. On 06/05/2012 at 12:25 p.m., resident #104 was asked if she had eaten lunch. The resident was unaware that it was lunch time or that she was in the restorative dining room. On 06/05/2012 at 12:45 p.m. an interview was conducted with NA #2 regarding the reason resident #104 was not at the table eating with the other residents and her lunch meal being uncovered and getting cold. NA #2 stated, "Resident #104 always moves away from the table." After the interview NA #2 was observed to bring resident #104 to the table and the resident began to eat her lunch meal - forty-five minutes after the other residents began eating. 2. Resident #64's medical record indicated the resident had diagnoses which included Dementia and Parkinson's disease. A review of the	F 241	Subsequently, all residents were immediately assessed for residual effects as a result of dining techniques. The DON, Administrator and Dietary Manager were responsible for assessing each resident in the process of dining to determine that no issues were related to each resident's dining experience.	

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F 241	Continued From page 2 resident's Care Plan dated 04/25/12 revealed the resident had Activities of Daily Living (ADL) deficits with, "Decreased ability to feed self related to - impaired cognition, contractures of the left wrist, and impaired decision making." The resident's quarterly Minimum Data Set (MDS) dated 04/20/2012 documented the resident as having severe cognitive impairment and being able to eat independently with food set up only. On 06/05/2012 a continuous observation was made of the restorative dining room between 12:05 p.m. and 12:15 p.m. from the dining room's doorway/hall. There was one restorative nursing assistant (NA #2) observed in the restorative dining room attending to ten residents. NA #2 was observed to rotating feeding between resident #64 and two other residents. NA #2 was observed to feed several bites of food to resident #64 while standing over the resident before rotating to the next resident. At 12:15 p.m. the continuous observation was continued from inside the restorative dining room where NA #2 was observed to continue to feed resident #64 several bites of food at a time while standing over the resident before rotating to the next resident. At 12:20 p.m. an additional staff member entered the restorative dining room and spoke to the NA #2 at which time the NA #2 started sitting next to each of the three residents while continuing to feed the residents. On 06/05/2012 at 12:45 p.m. an interview was conducted with NA #2 regarding her standing while feeding resident #64. NA #2 stated, "I know we are not supposed to feed the residents while we stand up but I was trying to get everything done as I am the only one in here, the other girl	F 241	Staff from all Departments, to include Restorative Feeding Team, nursing, administration, housekeeping, laundry and environmental services have been educated on aspects of resident dignity to include proper dining techniques. The education provided included the importance of sitting with the resident while eating, not standing over the resident, timeliness of assistance to ensure meal served at correct temperature as well as staff to report to dining room in a timely manner.	

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F 241	Continued From page 3 that is usually in here is off today." On 06/08/2012 at 7:45 a.m. the facility's Director of Nursing (DON) was interviewed concerning her expectation of facility staff feeding residents. The DON stated, "It is my expectation that all staff sit next to the resident, not stand next to the resident, while feeding the residents. 3. Resident #77's medical record indicated the resident had diagnoses which included Stroke with left side paralysis. A review of the resident's Care Plan dated 2/10/12 revealed the resident had Activities of Daily Living (ADL) deficits with, "Self care deficit, needs assistance eating and drinking, leaves more than 25% of meals related to - impaired cognition, and impaired decision making ability. The interventions listed on the care plan included, "Pace feeding to allow rest." The resident's unscheduled MDS dated 02/22/2012 documented the resident as being severely cognitively impaired and to need extensive one person assistance to eat. On 06/05/2012 a continuous observation was made of the restorative dining room between 12:05 p.m. and 12:15 p.m. from the dining room's doorway/hall. There was one restorative nursing assistant (NA #2) observed in the restorative dining room attending to ten residents. NA #2 was observed to feed several bites of food to resident #77 while standing over the resident before rotating to the next resident. At 12:15 p.m. the continuous observation was continued from inside the restorative dining room where NA #2 was observed to continue to feed resident #77 several bites of food at a time while standing over	F 241	In addition, an audit tool was created by the DON which includes dining observations for residents. Each resident will be observed on a weekly basis for the next 90 days, and random, thereafter by either the DON, Administrative nurses, Administrator or Dietary Manager. Audits will be discussed in morning administrative meetings and weekly administrative nurses meetings to ensure continued compliance. Any adverse observations will be addressed immediately with the individual staff member associated with such findings. In addition, the audits will be reviewed in our next QA meeting.	

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F 241	Continued From page 4 the resident before rotating to the next resident. At 12:20 p.m. an additional staff member entered the restorative dining room and spoke to the NA #2 at which time the NA #2 started sitting next to each of the three residents while continuing to feed the residents. On 06/05/2012 at 12:45 p.m. an interview was conducted with NA #2 regarding her standing while feeding resident #77. NA #2 stated, "I know we are not supposed to feed the residents while we stand up but I was trying to get everything done as I am the only one in here, the other girl that is usually in here is off today." On 06/08/2012 at 7:45 a.m. the facility's Director of Nursing (DON) was interviewed concerning her expectation of facility staff feeding residents. The DON stated, "It is my expectation that all staff sit next to the resident, not stand next to the resident, while feeding the residents. 4. Resident #114's medical record indicated the resident had diagnoses which included Syncope, Lack of Coordination, and Dementia. A review of the resident's Care Plan dated 03/20/2012 revealed the resident had Activities of Daily Living (ADL) deficits indicating the resident was, "At risk for imbalanced nutrition - less than body requirements." The interventions listed on the care plan included, "Staff to encourage resident to eat, offer food in small portions, and cut food into small bite size pieces." The resident's quarterly MDS dated 03/30/12 indicated the resident as being, "Severely cognitively impaired, and needing, Total assistance via one person assistance to eat."	F 241		

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F 241	Continued From page 5	F 241		

On 06/05/2012 a continuous observation was made of the restorative dining room between 12:05 p.m. and 12:15 p.m. from the dining room's doorway/hall. There was one restorative nursing assistant (NA #2) observed in the restorative dining room attending to ten residents. NA #2 was observed to feed several bites of food to resident #114 while standing over the resident before rotating to the next resident. At 12:15 p.m. the continuous observation was continued from inside the restorative dining room where NA #2 was observed to continue to feed resident #114 several bites of food at a time while standing over the resident before rotating to the next resident. At 12:20 p.m. an additional staff member entered the restorative dining room and spoke to the NA #2 at which time the NA #2 started sitting next to each of the three residents, one at a time while continuing to feed the residents.

On 06/05/2012 at 12:45 p.m. an interview was conducted with NA #2 regarding her standing while feeding resident #114. NA #2 stated, "I know we are not supposed to feed the residents while we stand up but I was trying to get everything done as I am the only one in here, the other girl that is usually in here is off today."

On 06/08/2012 at 7:45 a.m. the facility's Director of Nursing (DON) was interviewed concerning her expectation of facility staff feeding residents. The DON stated, "It is my expectation that all staff sit next to the resident, not stand next to the resident, while feeding the residents.

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F 241	Continued From page 6 5. Resident #50 was admitted to the facility with diagnoses which included Parkinson's, Alzheimer's, Dementia, Syncope, Failure to thrive, Muscle weakness, and Lack of Coordination. A review of resident # 50's Care Plan initially dated 03/01/2012 revealed the resident had Activities of Daily Living (ADL) deficits with eating, "At risk for imbalanced nutrition - less than body requirements." The Care Plan Interventions included, "Encourage oral intake of foods fluids, Monitor and record food intake, Monitor for signs and symptoms of malnutrition." The resident's quarterly MDS dated 03/30/12 documented the resident as being, "Severely cognitively impaired," and needing, "Limited assistance via one person for eating." On 06/05/2012 at 12:47 - 12:55 p.m., a continuous observation was made of the facility's main dining room from the dining room's main entry hall. The facility's MDS coordinator (nurse) was observed standing over resident #50 feeding the resident. At 12:55 p.m. the continuous observation was continued from inside the main dining room to continue observing the resident being fed by the MDS coordinator/nurse. On 06/05/2012 at 12:57 p.m. the facility's Director of Nursing (DON) was observed to enter the dining room and tell the MDS coordinator she was supposed to be seated when feeding the facility's residents. On 06/05/2012 at 1:00 p.m., an interview was conducted with the MDS coordinator. The MDS coordinator stated, "I have never fed the residents here, I am an old hospital nurse and there we would stand all the time. The DON told me I was supposed to be sitting down while feeding the	F 241		

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F 241	Continued From page 7 residents, I didn't know that." On 06/08/2012 at 7:45 a.m. the facility's DON was interviewed concerning her expectation of staff feeding residents. The DON stated, "It is my expectation that all staff sit next to the resident, not stand next to the resident, while feeding the residents. I had to tell the MDS coordinator to sit down when she was feeding the resident in the main dining room when you were observing the lunch meal."	F 241		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observation, resident and staff interview and record review, the facility failed to trim fingernails for 1 of 3 residents (Resident #36). The findings included: Resident #36 was last readmitted to the facility on 6/22/09. Cumulative diagnoses included hemiplegia. Resident #36's most recent Minimum Data Set (MDS), a quarterly dated 5/10/12, indicated that he had moderate cognitive impairment, did not reject care and was totally dependent on staff for personal hygiene. His care plan, dated 5/20/12, listed a problem of self care deficit and	F 312	Resident #36 nails were cleaned and trimmed on 6-8-12. The resident was assessed at that time for any residual effects of nails not being trimmed. An Audit/ Resident observation was done on 100% of resident by administrative nurses and the DON and nails were trimmed and cleaned if indicated.	6/18

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F 312	Continued From page 8 approaches included total care for all activities of daily living. On 6/6/12 at 10:15 AM, Resident #36 was observed with long fingernails. On 6/8/12 at 3:28 PM, Resident #36 was again observed with long fingernails, extending 1/8 to 3/16 of an inch beyond the tips of his fingers. At this time the resident was asked about his fingernails and he stated he did not like them being so long; they needed to be cut. During an interview on 6/8/12 at 3:30 PM, Nurse #2 stated that nail trimming was the responsibility of the nursing assistants (NA's) unless the resident had diabetes. Nurse #2 stated that the NA's did weekly skin audits on residents' shower days and nails should be trimmed then if needed. Nurse #2 indicated that she depended on the NA's to inform her of any problems. Nurse #2 observed Resident #36's fingernails and indicated they should be trimmed. A "Skin Audit" form, completed by NA #1, dated 6/6/12, indicated that Resident #36 refused his shower. The form included a section entitled "Preventive Care" under which included "Toenails/Fingernails need attention? ___Yes ___No ". The line for 'No" was checked. The form was also signed by Nurse #3. NA#1 was not available to be interviewed. During an interview on 6/8/12 at 3:45 PM, Nurse #3 indicated she signed the form to acknowledge that she had been made aware that Resident #36 had refused his shower.	F 312	Staff education was provided by the SDC and DON to include importance of proper nail hygiene and trimming. Staff were educated on their roles in providing nail care. Further education was provided on importance of accuracy on skin audit sheets. The DON developed an audit tool to track nail care and grooming in the facility. An audit will be done weekly for 90 days and then randomly thereafter by either the DON, Administrative Nurses and Administrator to ensure compliance. The audits will be discussed daily in morning administrative meetings and weekly in Administrative Nurses meetings	

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F 312	Continued From page 9 On 6/8/12 at 3:57 PM, Nurse #2 indicated that she trimmed Resident #36's nails. During an interview on 6/8/12 at 4:05 PM, the Director of Nursing (DON) indicated she expected the NA's to trim nails on shower days if needed.	F 312	Adverse findings will be discussed with the employee assigned and corrected immediately. In addition the audits will be reviewed in our next QA meeting.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and manufacturer specifications, the facility failed to remove a foil seal from the set port on an intravenous (IV) medication bag prior to inserting the IV administration set for 1 of 2 residents (Resident #159). The findings included: Manufacturer specifications for "cefazolin for injection" (an antibiotic for IV administration) read in part, "Using aseptic technique, peel foil cover from the set port and attach sterile administration set."	F 328	Resident #159 was assessed by DON and MDS nurse for any residual effects of improper technique, and it was determined that there was no adverse effect to the resident. An audit tool was developed and completed on all residents with IV medications to check for proper technique. One to one education was completed with the nurse involved to include following manufacturer's guidelines for adminstation of IV medications. In addition the nursing staff has been educated on the	7/3

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F 328	Continued From page 10 On 6/7/12 at 12:50 PM, Nurse #1 was observed preparing to administer cefazolin IV to Resident #159. The cefazolin was mixed with 50 milliliters of dilutent in an IV bag, to be administered over 30 minutes. The nurse was observed to insert the spike of the IV administration set through the foil seal covering the set port of the IV bag, prime the IV tubing with the cefazolin solution, and hang the bag. During an interview on 6/8/12 at 2:20 PM, the Staff Development Coordinator (SDC) stated that the foil seal on the IV bag should be peeled off prior to inserting the IV set. During an interview on 6/8/12 at 4:05 PM, the Director of Nursing (DON) stated that she expected the nurse to remove the foil seal prior to inserting the IV set. During an interview on 6/8/12 at 6:18 PM, Nurse #1 stated that the type of IV bag the cefazolin came in was new to the facility. The nurse explained that the spike of the IV set easily penetrated the foil seal and she did not believe it necessary to remove the foil. Nurse #1 added that she now knew to remove the foil seal.	F 328	manufactuer's recommendation for the duplex drug delivery system. The facility has scheduled an educational in-service on July 1st and 2nd, 2012 with the Pharmacy consulting RN on infusion equipment update. An audit tool was developed by the DON to monitor for usage of appropriate technique with IV medication administration. The audit will be done by the administrative nurses weekly for 90 days then randomly thereafter. The findings will be discussed in daily administration meetings and weekly in administrative nurses meeting. Any inconsistencies will be addressed immediately with the Nurses involved. In addition the audits sheets will be reviewed at our next QA meeting.	6/25
F 334 SS=B	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334		

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(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 334	Continued From page 11 immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding	F 334	F 334 Resident #7and resident #14 has been educated regarding the potential side effects of the influenza vaccine on 6/25/2011. This is documented in resident #7 and #14 medical record. An audit tool was developed and completed for all current residents who received the influenza vaccine for the 2011-2012 flu season addressing influenza education. Staff have been in-serviced on importance of educating resident/families on flu vaccine. The vaccine log has been revised for the 2012 and for additional seasons to include an area to indicate that education was provided to resident/family. The DON and administrative nurses will audit for	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING ______ B. WING ______	C 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(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 334	Continued From page 12 the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on staff interview and document review the facility failed to document provision influenza vaccination education annually for 2 of 5 residents (Resident #7 and Resident #14). Findings included: Review of the facility policy titled Influenza Vaccine revised November 2008 revealed, in part, " 8. Family and Resident will be educated on admission regarding influenza vaccine. " 1. Review of the immunization record for Resident #7 revealed she received the influenza vaccine on 12/22 (no year noted) and on 10/15/11. Review of the Influenza Immunization Informed Consent for Resident #7 revealed it listed some side effects of influenza vaccination as: " slight	F 334	compliance during the flu season. Any issues will be addressed immediately. We will discuss findings of audits in weekly administrative nurses meeting during the flu season. The audits will be reviewed in our scheduled QA meeting during that time period as well.	

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	345429	A. BUILDING ______ B. WING ______	C 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(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 334	Continued From page 13 discomfort; soreness of the arm; redness of the arm; slight fever (occasionally); and muscle aches (occasionally). " The form was signed by the Responsible Party and dated 10/6/10 under the section that read, in part, " I (name of representative), the responsible party for (name of resident), who is my (relationship) and resident of this facility, hereby give my permission for the facility to administer an influenza vaccination annually in the fall (October 1st through March 31st). " Documentation of provision of influenza education prior to receipt of the 2011 influenza vaccine dose was not present on the medical record. Interview with the Staff Development Coordinator (SDC) on 6/8/12 at 4:30 PM revealed that she mails the most current Vaccine Information Statement (VIS) on influenza vaccine to the Responsible party and/or discusses the information in the VISD with the resident annually. However, she stated that she did not document provision of this education in the medical record or anywhere else. The SDC added that whether or not the vaccine was given annually was documented in the medical record on the Immunization Record. She also stated that if a resident of RP refused previously but changed their mind and wanted the vaccine the following year, the Informed Consent form was redone but otherwise the Informed consent was only signed at admission. The SDC indicated that she did not think the regulations required annual documentation of influenza education in the medical record. Interview with the Administrator on 6/8/12 at 5 PM revealed that it was his understanding the facility	F 334		

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F 334	Continued From page 14 was following the education and documentation requirements for influenza vaccine correctly according to the regulations. 2. Review of the immunization record for Resident #14 revealed she received the influenza vaccine on 10/5/09 and on 10/30/11. Review of the Influenza Immunization Informed Consent for Resident #14 revealed it listed some side effects of influenza vaccination as: " slight discomfort; soreness of the arm; redness of the arm; slight fever (occasionally); and muscle aches (occasionally). " The form was signed by the resident and dated 3/24/10 under the section that read, in part, " I (name of resident) give my permission for the facility to administer an influenza vaccination annually in the fall (October 1st through March 31st). Documentation of provision of influenza education prior to receipt of the 2011 influenza vaccine dose was not present on the medical record. Interview with the Staff Development Coordinator (SDC) on 6/8/12 at 4:30 PM revealed that she mails the most current Vaccine Information Statement (VIS) on influenza vaccine to the Responsible party and/or discusses the information in the VISD with the resident annually. However, she stated that she did not document provision of this education in the medical record or anywhere else. The SDC added that whether or not the vaccine was given annually was documented in the medical record on the Immunization Record. She also stated that if a resident of RP refused previously but changed their mind and wanted the vaccine the following year, the Informed Consent form was redone but	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING ______ B. WING ______	C 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(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 334	Continued From page 15 otherwise the Informed consent was only signed at admission. The SDC indicated that she did not think the regulations required annual documentation of influenza education in the medical record. Interview with the Administrator on 6/8/12 at 5 PM revealed that it was his understanding the facility was following the education and documentation requirements for influenza vaccine correctly according to the regulations.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o 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: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. 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	F 356	The daily nursing staffing sheets identified by the surveyors were corrected at that time. The facility reviewed the staffing sheets for the past 6 months and corrected the forms if indicated. One to one education was provided to the staffing coordinator to ensure understanding of staff that are supposed to be listed on the form. Education was provided on importance of having census on form daily as well. Education was provided to the third shift nurses to write the census on the form when it is changed out daily.	6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING ______ B. WING ______	C 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

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F 356	Continued From page 16 standard. 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 and staff interview, the facility failed to post accurate staffing information and include the census on the staff posting. The findings included: Observations on 6/5/12 and 6/8/12 revealed a "Daily Nursing Department Staffing Form" posted across from the 100/200/300 hall nurses' station. On both aforementioned days the form indicated that 4 RN's (registered nurses) and 3 LPN's (licensed practical nurses) were providing direct resident care on the 7-3 shift. The resident census field was blank on both days. During an interview on 6/8/12 at 5:15 PM, the Director of Nursing (DON) said that the 3 LPN's were the hall nurses. The RN's included the treatment nurse, the unit manager and 2 MDS (Minimum Data Set) nurses. The DON added that the MDS nurses and unit manager sometimes helped the hall nurses when needed for specific tasks, such as inserting an intravenous access device, but did provide direct resident care for the majority of their duty time. The DON amended the form of 6/8/12 to reflect 1 RN (the treatment nurse) for the 7-3 shift. The DON acknowledged that no census was recorded on the form, and that the form did not have a field in which to record the census at the beginning of each shift.	F 356	The nursing coordinator will follow up at the beginning of her shift to ensure census is on form and make correction for staffing if indicated. The DON and weekend supervisor will check sheet daily to ensure compliance with standards. Any issues will be addressed immediately. Compliance will be reviewed daily in administrative meetings. In addition we will review compliance at our next QA meeting.	

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	345429	A. BUILDING ______ B. WING ______	C 06/08/2012

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F 356	Continued From page 17 The DON indicated she would educate the staff member responsible for the posting. The staff member responsible for completing the staffing form was not available for interview.	F 356		

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING 01 - BUILDING 0101 B. WING	07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(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
K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V protected construction, and is utilizing Delayed Egress Locking Systems . The facility is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000		
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/3/2012 The sprinkler heads installed in room 108 were a mix of a quick response head and a standard fused head. Actual NFPA Standard: NFPA 13,5-3,1.5.2 CFR#: 42 CFR 483.70 (a)	K 062	Filing the plan of correction does not constitute and omission that the deficiencies alleged did in fact exist. This plan of correction is filled as evidence of the facilities desire to comply with the requirements and to continue to provide high quality of care. Environmental Services Director immediately contacted the sprinkler company and ordered appropriate sprinkler head. The sprinkler head will be replaced in the identified location.	8/10/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Bernard Bryant TITLE: Administrator (X6) DATE: 7/18/12

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

ENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING 02 - NEW REHAB ADDITION B. WING ______	07/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This portion of the facility is the new rehabilitation building and it is Type V protected construction. The facility is equipped with an automatic sprinkler system. There were no Life Safety Code Deficiencies noted during the survey. CFR#: 42 CFR 483.70 (a)	K 000	A complete inspection of the entire building was conducted by the Environmental Services Director to determine that no other areas in the facility were compromised. No further issues were noted from inspection. Environmental Services Director will conduct monthly inspections to determine continued compliance, regarding the ongoing use of similar sprinkler heads throughout the facility. Also a contracted sprinkler company will conduct annual inspections as well. Any discrepancies will be discussed with the Administrator and any issues found, based on inspections, will be brought to the facility safety committee meeting each month.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ben Ryal	Administrator	7/18/12

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