SEP 18 2013

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

PRINTED: 08/20/2013
FORM APPROVED
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 _____ B. WING _____	C 08/09/2013

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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician interview, the facility failed to notify the physician when Lasix (a diuretic medication) was	F 157	Filing this Plan of Correction does not constitute 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. Resident # 176 chart was reviewed by the Director of Nursing, the physician was made aware that the Lasix had been withheld and it was determined by the resident's attending physician that there was no negative outcomes as a result of this medication being withheld.. **Action taken regarding all others with the potential to be affected** A thorough MAR review was completed by the administrative nurses for all current residents using the developed audit tool to determine the presence of any withheld medications. Ten omissions were identified and the attending physician was notified by the ADON and the attending physician determined there were no negative outcomes regarding any of the identified omissions.	8/9/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 9/13/13

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 157	Continued From page 1 held due to low pressure for 1 of 6 sampled residents (Resident #176). The findings included: Resident #176 was admitted to the facility on 6/14/13. Diagnoses included heart failure, hypertension, atrial fibrillation, chronic kidney disease and pneumonia. Admission physician orders dated 6/14/13 included Lasix 40 milligrams (mg) daily. Lexicomp's "Geriatric Dosage Handbook" 17th Edition includes hypotension under Adverse Reactions and blood pressure under Monitoring Parameters. The Medication Administration Record (MAR) indicated that the Lasix was held on 6/19, 6/21, 6/22, 6/24, 6/25, 6/28, and 6/29. Recorded blood pressures included: on 6/19: 99/44, on 6/21: 95/50, on 6/25: 98/51, on 6/28: 96/63 and on 6/29/: 98/58. There was no indication in the medical record that the physician had been notified of the low blood pressure. During an interview on 8/8/13 at 2:37 PM, Nurse #7 acknowledged she had held the resident's Lasix on 6/24, 6/25 and 6/28. Nurse #7 stated her practice, based on nursing judgment, was to hold blood pressure medications whenever a resident's blood pressure was less than 100/60. The nurse added she would notify the physician and document on the nurse's notes. The nurse acknowledged documentation was lacking, and stated she may have verbally informed the physician or nurse practitioner. During an interview on 8/9/13 at 9:05 AM, the	F 157	**Measures put in place** All licensed nursing staff were educated by the SDC on or before 8/28/2013 regarding the requirement to contact the attending physician when it is necessary to withhold a medication. The nursing staff's education included documentation requirements which indicated the need to include the attending physician's agreement and support of the nurse's rational. This education will be completed by the SDC Nurse. The education included Notification of Physician, resident, family member, as well as the documentation requirements when with holding a medication. Any staff on vacation or leave will receive education before returning to work.	

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F 157	Continued From page 2 physician stated he would expect to be notified if Lasix was held due to low blood pressure.	F 157	**Monitoring** The DON has developed and audit tool that consists of the following observations: 1. did the resident have any medication withheld during the last week; 2. is there evidence that the Doctor was notified; and 3. Were any new orders given as a result of medications being withheld. The DON or administrative nurse will audit 25% of charts to include the MARs weekly for two weeks, then 10% of charts to include the MARs weekly for six weeks then monthly for six months to ensure continued compliance. Continued audits will be based on the results of the previous audits. The audits will be reviewed and trended in the weekly administrative nursing meeting. QA follow up will be reviewed during the facility's next scheduled QA committee meeting to ensure continued compliance. It was verified during the 8-15-13 Administrative nurses meeting that QA nurse completed audits on 8-11, MDS nurse #2 completed audits on 8-9, and SDC nurse completed audits on 8-9. It was verified that on 8-20 Administrative nurses meeting it was verified that SDC nurse completed audits on 8-20 and QA nurse completed audits on 8-20. It was verified on 8-29 Administrative nurses meeting that QA nurse completed audits on 8-27 and 8-28. It was verified at 9-8 Administrative nurses meeting that QA nurse completed audits on 9-3. Going forward the DON will assign an Administrative nurse to the audits for the next week and this will be documented in the minutes of the meeting.	8/11/13 8/10/13
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 family, resident and staff interview and record review the facility failed to meet resident ' s needs for toileting and incontinence assistance when call bells were not answered timely for 3 of 5 sampled residents (Resident #25, #3 and #118). Findings include: 1. Resident #25 was admitted to the facility on 4/25/13 with diagnoses including: dysphasia, glaucoma of left eye and prosthetic right eye, and status post open reduction of left ankle fracture on 12/12/12. The most recent Minimum Data Set (MDS), a quarterly assessment dated 4/6/13 indicated Resident #25 was cognitively intact. It also revealed she needed extensive assistance with transfers, personal hygiene and toileting and that she was frequently incontinent of bowel and bladder. On 8/5/13 at 11 AM a family member of Resident #25 stated that call bells were not answered timely on second shift between 5 - 9 PM and particularly after 7 PM when one staff member	F 241		

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F 241	Continued From page 3 always left and the assignment had to be changed. She also said that there was no nursing supervisor on second shift. The family member alledged that staff assigned to the same hall took breaks at the same time and sometimes left the facility during breaks for an hour or so. She stated that the nurses did not answer call bells when the Nursing Assistants could not and that she had seen Nursing staff eating at the nursing station and ignoring call bells. Observations were made on 8/7/13 from 8:10 PM - 9:10PM of 3-11 shift staff response to call lights. Upon entry at 8:10 PM there was one nurse and six nursing assistants available to answer call lights. Up to 4 lights were observed on at one time. During the observation period, there was less than a ten minute span in which no call lights were on. On 8/7/13 at 8:40 PM., Administrative staff #1 stated the staff member in charge on the 3-11 shift and 11-7 shift was the 200/300 hall nurse. Administrative Staff #1 indicated that since she frequently stayed at the facility until 7 PM, and often came back to the facility after that, the observations of Administrative Staff assisting to answer call bells quickly after 8 PM were not unusual. During an interview on 8/7/13 at 9:15 PM, Nurse #6 (200/3000 hall Nurse) stated she regularly worked the 3-11 shift and the call light activity during the past hour was typical. She stated staff answered call lights as quickly as possible but had no estimate of the length of time any given call light may be on before it was answered. Nurse #6 also said that it was not unusual for one of the nursing assistants to only work until 7:00	F 241	Residents # 3, 25, 118 were assessed by MDS nurse #1 on 8/10/2013 to ensure all current needs are being met in a timely and efficient manner to include assistance with all ADL care. The assessment consisted of an observation by the administrative nurses to include all necessary aspects of specific ADL care required for each individual resident. There were no discrepancies identified regarding these residents and the documentation in each of the resident's care plan was reviewed for accuracy. **Action taken regarding all others with the potential to be affected** All current residents have been assessed by administrative nurses to determine that all needs are being met in a timely and efficient manner to include assistance with all ADL care. All assessments have been verified by the DON to determine each administrative nurse's compliance in accordance with the plan of correction.	8/11/13

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F 241	Continued From page 4 PM, leaving six nursing assistants to cover the floor. When asked if she was the supervisor for 3 - 11 shift she indicated that she was not but after being informed that Administrative Staff #1 indicated the 200/300 hall Nurse was always assigned to be in charge on 3 - 11, she revealed that she was the person assigned to make changes to the staffing schedule. On 8/8/13 at 5:15 PM NA #6 was interviewed. She stated that the facility was short of help especially after 7 PM since staffing was cut to 6 aides after 7 PM. She added that staff was busy after 7 PM putting residents back to bed, doing incontinent care and call bells would be going crazy. NA #6 said that last night (8/7/13) after 7 PM, the state surveyors were in the building and the administrative staff was the one answering the call lights. On 8/9/13 at 9:35 AM Administrative Staff #4 was interviewed and revealed that on June 26/13 at around 8:30 PM she observed call bells go unanswered for 10 - 15 minutes on 300 hall and then located the two Nursing Assistants assigned to the hall on break together in the Restorative room. She indicated that she gave these two Nursing Assistants a written warning. She stated that the Nursing Assistants said they told the hall Nurse they were going on break together and where they would be and the Nurse had suggested Administrative Staff #4 look for the Nursing Assistants in the Restorative Room. There was no disciplinary action for the Nurse. 2. Resident #3 was admitted to the facility on 12/26/05 and readmitted 6/14/13. Diagnoses included anemia, heart failure, hypertension, dementia, anxiety and depression.	F 241	**Measures put in place** All nursing staff including certified nursing assistants, housekeeping, maintenance, therapy department, dietary and licensed nurses will be educated the SDC on the importance of answering call bells timely a "no passing zone" was included in this education as was providing timely assistance with the desired task when the call bell is answered. The "No Passing Zone" initiative instructs ALL STAFF to respond to call bell lights and not to PASS by a room that has an activated call light. The facility's expectations regarding call light response times are that every reasonable effort will be made to respond to a call light within ten minutes. If non-nursing staff answers the call light and the resident needs assistance from nursing, the non-nurse staff will summons help and the call light will remain activated until the need is addressed. This education will be completed by 08/30/2013. Any staff on vacation or leave will receive education prior to returning to work. All staff will be educated regarding the acceptable practice of toileting/changing during mealtimes based on the need of each resident. **Monitoring** The facility has developed an audit tool to monitor Call bells. Call bells will be audited over all three shifts daily for one week, then at least weekly for seven weeks, then monthly for six months to ensure continued compliance. Further audits will be based on the results of previous audits. All concerns	8/30/13 8/11/13

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F 241	Continued From page 5 The most recent Minimum Data Set (MDS), a quarterly assessment dated 6/7/13, indicated Resident #3 had severe cognitive impairment, sometimes was understood and sometimes understands, required extensive assistance of 1 person for transfers and toileting, and was occasionally incontinent of bowel and bladder. On 8/5/13 at 1:30 PM, two family members of Resident #3 stated that the resident had to wait 30 - 50 minutes for her call light to be answered after supper. They indicated that the resident was incontinent at times because she had to wait so long for assistance. They also alleged they had seen nursing assistants come in to turn off the call light but not address the resident's reason for calling. On 8/7/13 at 11:30 AM another family member of Resident #3 said that the resident was not getting assistance to the bathroom as needed after supper. The family member said she would put the call light on but response was very slow, sometimes close to an hour. Observations were made on 8/7/13 from 8:10 PM - 9:10PM of 3-11 shift staff response to call lights. Upon entry at 8:10 PM there was one nurse and six nursing assistants available to answer call lights. Up to 4 lights were observed on at one time. During the observation period, there was less than a ten minute span in which no call lights were on. On 8/7/13 at 8:40 PM., Administrative staff #1 stated the staff member in charge on the 3-11 shift and 11-7 shift was the 200/300 hall nurse. Administrative Staff #1 indicated that since she	F 241	will be addressed immediately to include specific audits related to the actual assigned shift and location of concern. The audits will be reviewed and trended weekly during the administrative nursing meetings. The audits will be reviewed at the next scheduled QA committee meeting to ensure continued compliance. Monitoring will consist of 30 minute observations on each shift. Call bells will be audited over all three shifts including weekends. It was verified during the 8-15-13 Administrative nurses meetings that SDC completed audits on 8-10, 8-11, 8-12, 8-13, 8-14, 8-15 and 8-16, ADON completed audits on 8-10, 8-11, 8-12, 8-13 and 8-16, DON completed audits on 8-11, QA nurse completed audits on 8-17. During the 8-20 Administrative nurses meeting it was verified that QA nurse completed audits on 8-17, ADON and SDC completed audits on 8-16. It was verified during the 8-29 Administrative nurses meeting that QA nurse completed audits on 8-24. It was verified during the 9-8 Administrative nurses meeting that QA nurse completed audits on 8-29 and 9-5 and that DON completed audits on 9-6 and 9-8. Going forward the DON will assign the Administrative nurses audits to complete for the next week and this will be reflected in the meeting minutes.	

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F 241	Continued From page 6 frequently stayed at the facility until 7 PM, and often came back to the facility after that, the observations of Administrative Staff assisting to answer call bells quickly after 8 PM were not unusual. During an interview on 8/7/13 at 9:15 PM, Nurse #6 (200/3000 hall Nurse) stated she regularly worked the 3-11 shift and the call light activity during the past hour was typical. She stated staff answered call lights as quickly as possible but had no estimate of the length of time any given call light may be on before it was answered. Nurse #6 also said that it was not unusual for one of the nursing assistants to only work until 7:00 PM, leaving six nursing assistants to cover the floor. When asked if she was the supervisor for 3 - 11 shift she indicated that she was not but after being informed that Administrative Staff #1 indicated the 200/300 hall Nurse was always assigned to be in charge on 3 - 11, she revealed that she was the person assigned to make changes to the staffing schedule. On 8/8/13 at 5:15 PM NA #6 was interviewed. She stated that the facility was short of help especially after 7 PM since staffing was cut to 6 aides after 7 PM. She added that staff was busy after 7 PM putting residents back to bed, doing incontinent care and call bells would be going crazy. NA #6 said that last night (8/7/13) after 7 PM, the state surveyors were in the building and the administrative staff was the one answering the call lights. On 8/9/13 at 9:35 AM Administrative Staff #4 was interviewed and revealed that on June 26/13 at around 8:30 PM she observed call bells go unanswered for 10 - 15 minutes on 300 hall and	F 241		

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F 241	Continued From page 7	F 241		

then located the two Nursing Assistants assigned to the hall on break together in the Restorative room. She indicated that she gave these two Nursing Assistants a written warning. She stated that the Nursing Assistants said they told the hall Nurse they were going on break together and where they would be and the Nurse had suggested Administrative Staff #4 look for the Nursing Assistants in the Restorative Room. There was no disciplinary action for the Nurse.

3. Resident # 118 was admitted to the facility 12/21/11. Cumulative diagnoses included: chronic respiratory failure and CHF (congestive heart failure).

A Quarterly Minimum Data Set (MDS) dated 6/1/13 indicated Resident # 118 was cognitively intact. She required extensive assistance with toileting and limited assistance with personal hygiene. Resident # 118 was frequently incontinent of bladder and bowel.

A Grievance report dated 7/25/13 by Resident # 118 stated, in part, that the nursing staff did not answer the call bell in a timely manner.

On 8/7/13 at 4:01 PM., an interview was conducted with Resident # 118. She said she went to bed around 8:00PM and would not have her incontinent brief changed until after 11:00 PM Resident stated there were times she turned on the light, the nursing staff would come and turn the light off and say they would be back but they did not return. Resident # 118 indicated she got up around 9:00 AM. She would ring for toileting assistance in changing her incontinent brief and, at times, nursing staff would tell her that the food trays were being put on the hall and she had not

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F 241	Continued From page 8 been changed until after they had picked up the trays or received her bath for morning care. Observations were made on 8/7/13 from 8:10 PM - 9:10PM of 3-11 shift staff response to call lights. Upon entry at 8:10 PM there was one nurse and six nursing assistants available to answer call lights. Up to 4 lights were observed on at one time. During the observation period, there was less than a ten minute span in which no call lights were on. On 8/7/13 at 8:40 PM., Administrative staff #1 stated the staff member in charge on the 3-11 shift and 11-7 shift was the 200/300 hall nurse. Administrative Staff #1 indicated that since she frequently stayed at the facility until 7 PM, and often came back to the facility after that, the observations of Administrative Staff assisting to answer call bells quickly after 8 PM were not unusual. During an interview on 8/7/13 at 9:15 PM, Nurse #6 (200/3000 hall Nurse) stated she regularly worked the 3-11 shift and the call light activity during the past hour was typical. She stated staff answered call lights as quickly as possible but had no estimate of the length of time any given call light may be on before it was answered. Nurse #6 also said that it was not unusual for one of the nursing assistants to only work until 7:00 PM, leaving six nursing assistants to cover the floor. When asked if she was the supervisor for 3 - 11 shift she indicated that she was not but after being informed that Administrative Staff #1 indicated the 200/300 hall Nurse was always assigned to be in charge on 3 - 11, she revealed that she was the person assigned to make changes to the staffing schedule.	F 241		

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F 241	Continued From page 9 On 8/8/13 at 5:15 PM NA #6 was interviewed. She stated that the facility was short of help especially after 7 PM since staffing was cut to 6 aides after 7 PM. She added that staff was busy after 7 PM putting residents back to bed, doing incontinent care and call bells would be going crazy. NA #6 said that last night (8/7/13) after 7 PM, the state surveyors were in the building and the administrative staff was the one answering the call lights. On 8/9/13 at 9:35 AM Administrative Staff #4 was interviewed and revealed that on June 26/13 at around 8:30 PM she observed call bells go unanswered for 10 - 15 minutes on 300 hall and then located the two Nursing Assistants assigned to the hall on break together in the Restorative room. She indicated that she gave these two Nursing Assistants a written warning. She stated that the Nursing Assistants said they told the hall Nurse they were going on break together and where they would be and the Nurse had suggested Administrative Staff #4 look for the Nursing Assistants in the Restorative Room. There was no disciplinary action for the Nurse.	F 241		
F 312 SS=E	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:	F 312	Residents # 3,25,107,4 and 118 were assessed by DON. No negative outcomes were associated with this citation. For personal hygiene Resident #25 had no negative outcomes from this citation. Resident #25 has an	8/11/13

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F 312	Continued From page 10 Based on record review, observation, resident, family and staff interview, the facility failed to follow their policy in providing incontinent care to 1 (Resident # 4) of 3 sampled residents who needed extensive assist to total assistance with toileting/personal hygiene, failed to provide timely incontinent care/toileting for 4 (Resident #25, #107, #3, and #118) of 7 sampled residents and failed to provide personal hygiene for a resident's eye area to keep it free of matter for 1 (Resident #25) of 7 sampled residents.. The findings included: 1. The facility's policy on perineal care dated May, 2007 was reviewed. The policy read in part: " wet washcloth and apply soap or skin cleansing agent when heavily soiled, otherwise disposable wipes/periwash is sufficient. Wash perineal area, wiping from front to back. Separate labia, and wash area downward from front to back. Continue to wash the perineum moving from inside outward to and including thighs, alternating from side to side and using downward strokes. Do not reuse the same wash cloth or water to clean the urethra or labia. Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth. Rinse washcloth and apply soap or skin cleansing agent. Wash the rectal area thoroughly, wiping from the base of the labia towards and extending over the buttocks. Do not reuse the same washcloth or water to clean the labia. Rinse thoroughly using the same technique. Dry area thoroughly. " Resident #4 was admitted to the facility on 5/9/11 with multiple diagnoses including coronary artery disease (CAD). The quarterly Minimum Data Set (MDS)	F 312	appointment for polishing and cleaning artificial eye that was scheduled Prior to the surveyors entering the facility and the staff will continue to clean around eye in an ongoing attempt to keep eye clear of matter. **Action taken regarding all others with the potential to be affected** All current residents have been assessed by administrative nurses to ensure that proper personal hygiene and assistance with ADL care is being provided. In addition, all current residents that require incontinent care have been observed to ensure that appropriate incontinence care is being provided. The Care Plans for all current residents were reviewed by the administrative nurses to ensure that all ADL and incontinent needs were identified and also communicated to the staff. This assessment was completed by 8/11/2013 and assessment validation was documented on a resident census sheet. These observations were conducted by the administrative nurses. The resident care plan assessment that was conducted included a review to determine if any revisions were needed regarding any special care needs.	8/11/13

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F 312	Continued From page 11 assessment dated 6/13/13 indicated that Resident #4's cognition was intact, always incontinent of bowel and bladder and needed extensive assist with toileting and personal hygiene. The assessment further indicated that she needed extensive assist of 2 person with transfer. The care plan was reviewed. The care plan for activities of daily living (ADL) dated 6/13/13 revealed a problem " resident's ability to perform in ADLs are impaired " and the goal was " resident will not further deteriorate in ADLs. " The approaches included " provide extensive assist in bed mobility, transfers and toileting. " On 8/7/13 at 2:50 PM, Resident #4 was observed during incontinent care. NA #3 (nursing assistant) was observed to stand the resident up using the stand up lift, pulled her pants down, removed the soiled diaper, put on a new diaper, fastened it and pulled her pants up.. NA #3 proceeded to put the resident in the electric wheelchair. NA #3 was not observed to clean the resident's perineal/rectal area. At 3:55 PM, NA #3 was interviewed. She agreed that she did not clean the resident because the resident was tired standing up, but she would lift her again and clean her up. At 3:58 PM, while sitting in the electric chair, Resident #4 had asked to use the toilet to have a bowel movement. NA #3 was observed to put the resident on a stand up lift and placed her in the commode. The resident had a bowel movement. NA #3 was observed to wet a washcloth with water and cleaned the rectal area. NA #3 was not observed to use soap to clean the rectal area. NA #3 was not observed to clean the perineal area. NA#3 was observed to pull and to fasten the diaper, pulled her pants up	F 312	**Measures put in place** All nurses and CNAs have been educated by the SDC on facility policy for incontinent care and providing assistance with ADL care. This education includes proper perineal care, incontinent care and grooming. Proper technique and supplies were also discussed as part of the education. This education will be completed by 08/30/2013 to allow for any staff on vacation. The facility has developed an audit tool to monitor incontinent care and ADL care to include proper personal hygiene. The audit tool consists of the following components: 1. Did the auditor observe incontinent care; 2. Was incontinent care provided according to policy; 3. Was the resident made comfortable after care; and 4. Has the employee been educated on appropriate incontinent care. The audit tool will therefore determine compliance with facility's procedures. As of 9/14/2013 DON revised the audit forms to include 1. Were all grooming needs met; 2.Were needs met timely. By revising this on the audit tool we will ensure that all resident's personal hygiene needs and incontinent care will be met in a timely manner. The audits will be conducted by the administrative nurses. All residents will be observed over the course of all three shifts using the audit tool by 9/12/2013. Thereafter weekly audits will	8/30/13 8/11/13

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F 312	Continued From page 12 and put her to bed using the stand-up lift. NA #3 was not observed to provide incontinent care while Resident #4 was in bed. At 4:05 PM, the treatment nurse was observed to provide treatment to the open area on the right buttock. On 8/7/13 at 4:30 PM, Resident #4 was interviewed. She stated that the staff had provided incontinent care by using the stand up lift everyday when she was out of bed. She stood up and the staff changed her diaper. She was not paying attention as to how they cleaned her up because she was trying to hold on to the lift. She added that the nurse's aide from the 11-7 shift had to put her on the chair every morning and the nurse's aide from the 7-3 shift had to put her back to bed. On 8/9/13 at 8:45 AM, NA #3 had provided additional information. She stated that she had used one wash cloth to clean the resident's perineal and rectal area. She added that she had rinsed the wash cloth in between. She also indicated that it was hard to clean her up good because she was standing up and was tired being on the lift. On 8/9/13 at 8:50 AM, administrative staff #1 was interviewed. She was in the room when NA #3 was providing additional information. She indicated that she expected NA #3 to use 2 washcloth but because the resident was on the lift and was hard to clean on a stand up position, it was acceptable to clean her that way. 2a. Resident #25 was admitted to the facility on	F 312	be conducted for the next six weeks to include ten percent of residents each week then monthly for six months to ensure continued compliance. Any issues that are identified regarding staff performance will result in further education to include return demonstration. The results of these audits will be discussed and trended in the weekly administrative nursing meeting and will be reviewed during the next scheduled QA committee meeting to ensure continued compliance with the policy and procedures regarding incontinent care and ADL care to include personal hygiene. It was verified during the 8-15 Administrative nurses meeting that SDC completed audits on 8-11, 8-12, 8-13, 8-14, 8-15 and DON completed audits on 8-14. It was verified during Administrative nurses meeting that the QA nurse completed audits on 8-17, SDC completed audits on 8-16 and DON completed audits on 8-19. It was verified during 8-29 Administrative nurses meeting that the QA nurse completed audits on 8-27. It was verified during the 9-8 Administrative nurses meeting that QA nurse completed audits on 9-3 and 9-5, DON completed audits on 9-6 and 9-8 and MDS nurse #1 completed audits on 9-4. Going forward the DON will assign Administrative nurses audits to complete	

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F 312	Continued From page 13 4/25/13 with diagnoses including: dysphasia, glaucoma of left eye and prosthetic right eye, and status post open reduction of left ankle fracture on 12/12/12. The most recent Minimum Data Set (MDS), a quarterly assessment dated 4/6/13 indicated Resident #25 was cognitively intact. It also revealed she needed extensive assistance with transfers, personal hygiene and toileting and that she was frequently incontinent of bowel and bladder. The Immediate Care Plan dated 6/12/13 revealed the following goals: return to usual level of continence for bowel and bladder function with an intervention checked to assist with toileting. The Comprehensive Care Plan dated 6/12.13 revealed a problem state met that Resident #25 was at risk for poor hygiene which included an intervention to provide limited assistance for activities of daily living. Review of the Concern/Grievance Reporting Form dated 7/12/13 revealed that Resident #25 had a complaint that " I wet my pants before the aide changed me. " Under the heading Follow-up Action the following, in part, was written: " it was determined that resident had incontinent episode in therapy and wet her clothes - continue (with) staff education on importance of checking (with) resident on and educated resident on importance of requesting care when needed. " On 8/5/13 at 11 AM a family member of Resident #25 stated that call bells were not answered timely on second shift between 5 - 9 PM and particularly after 7 PM when one staff member	F 312	for the next week and this will be noted in the meeting minutes. We as a facility have instituted a resident and family monitoring tool/interview system that will assist in determining the presence of areas of concern whereby each department manager is assigned a specific resident /family each week to interview which will allow the facility to further determine continued compliance	

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always left and the assignment had to be changed. The family member alledged that staff assigned to the same hall took breaks at the same time and sometimes left the facility during breaks for an hour or so. She stated that the nurses did not answer call bells when the Nursing Assistants could not and that she had seen Nursing staff eating at the nursing station and ignoring call bells. The family member added that Resident #25 was not being taken to the bathroom as needed and during meal times staff would not take residents to the bathroom. The family member indicated that if Resident #25 was assisted with toileting she would not be incontinent and she recalled two occasions when Resident #25 ' s dress had been soaked with urine.

On 8/6/13 at 6:00PM., NA #1 stated there was one nursing assistant on the hall for the evening meal while the other was in the dining room. The one on the hall passed out the trays and fed the residents on the hall. When asked what she would do if someone wanted to be toileted or changed during the mealtime, NA #1 hesitated in answering, then said she would change them after the cart on the hall was gone off the hall.

On 8/6/13 at 6:00 PM., Nurse #4 stated nursing staff did not change or toilet residents while the tray cart was on the hall.

On 8/7/13 at 11:13 AM., NA #2 stated she had always been told not to toilet or change anyone while the trays were out on the hall. If food was in the room for the resident who had requested to have their incontinent brief changed or to be toileted or the roommate in the room, she would tell them she would toilet and/or change them

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F 312	Continued From page 15 after the trays were picked up. She said she tried to avoid that problem by asking and or changing residents prior to the meal so that would not happen. On 8/7/13 at 8:40 PM., Administrative staff #1 stated the person in charge on the 3-11 shift and 11-7 shift was the 200/300 hall nurse. Administrative staff #1 indicated that nursing staff can toilet residents or provide incontinent care during meals. She said there was one nursing assistant on the hall at meal time but the nurse assisted in answering call lights and any staff, even housekeeping, could find out what the resident needed. During meals, the nursing assistant would ask the roommate if the food tray could be removed during care and brought back afterwards. Administrative staff had no idea why some nursing staff would say they could not provide toileting/ incontinent care and she would need to in-service the staff. 2b. Resident #25 was admitted to the facility on 4/25/13 with diagnoses including: dysphasia, glaucoma of left eye and prosthetic right eye, and status post open reduction of left ankle fracture on 12/12/12. The most recent Minimum Data Set (MDS), a quarterly assessment dated 4/6/13 indicated Resident #25 was cognitively intact. It also revealed she needed extensive assistance with transfers, personal hygiene and toileting and that she was frequently incontinent of bowel and bladder. The Comprehensive Care Plan dated 6/12.13 revealed a problem state met that Resident #25 was at risk for poor hygiene which included an	F 312		

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F 312	Continued From page 16 intervention to provide limited assistance for activities of daily living. Observation on 8/7/13 at 8:15 PM revealed Resident #25 was resting in bed with a family member at her bedside. Resident #25 had yellow matter on her right eyelashes and over the top 1/8th of her artificial R eye. Resident #25 stated she had already had bedtime care. The family member stated that it was not Resident #25 ' s practice to have her artificial eye removed for cleaning daily but that the staff should be wiping Resident ' s eyes to keep them clean but were not. Observation on 8/8/13 at 8:30 AM revealed Resident #25 was awake in bed and had finished her breakfast. The yellow matter remained on her right eyelashes and extended over the top 1/8th of her artificial eye. Observation on 8/8/13 at 2:30 PM revealed Resident #25 did not have yellow matter on her R eye area anymore however the eyelashes of her right eyelid were bent inwards and stuck to her artificial eye. She indicated that her right eye area was uncomfortable and she thought she used to have eye drops for that eye. Interview with Nurse #7 on 8/8/13 at 3 PM revealed that she was aware Resident #25 ' s common practice was to leave her artificial eye in, instead of removing it for cleaning daily, so facility staff just needed to help her keep it clean. Nurse #7 was informed of the above observations of Resident #25 and the Resident ' s comment about eye area discomfort and eye drops. Nurse #7 said she would talk to the physician about it and that he would be seeing Resident #25 on	F 312		

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F 312	Continued From page 17 8/9/13. Observation of Resident #25 on 9/9/13 at 9:55 AM revealed she had no yellow matter in her eyes and the eyelashes of her right eye were no longer stuck to her artificial right eye. 3. Resident #107 was admitted to the facility on 6/13/13. Diagnoses included diabetes mellitus type 2, acute myocardial infarction, muscle weakness, and dementia. The admission Minimum Data Set (MDS) dated 6/20/13 revealed the resident had moderate cognitive impairment, required extensive assistance of 2 persons for transfers and extensive assistance of 1 person for toileting. The care plan dated 6/24/13 included toilet every 2 hours, incontinence care after each episode and use absorbent, skin-friendly pads/briefs. On 8/7/13 at 9:45 AM, family members indicated during an interview that the resident was sometimes found very wet and/or soiled to the extent that the incontinent product was saturated and her clothes were wet and soiled. The family added that they did her laundry so they were aware this was a periodic but ongoing problem. The family added that they have filed one grievance since admission, regarding the facility not changing the resident from the time she was admitted until the next morning, after the family had arrived. The family explained that the facility uses a different kind of incontinence product than the hospital, and they recognized that the product from the hospital was still on the resident the morning of 6/14/13.	F 312		

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F 312	Continued From page 18 The nursing assistant who was assigned to the resident on the 11-7 shift on 6/13-6/14/13 was no longer employed at the facility. During the survey, the resident was observed to be up, dressed and groomed every morning by 8:00 AM. No odors of incontinence were observed. During the survey, family members of 3 other residents raised concerns that residents were not assisted to the toilet or provided incontinent care often enough to prevent accidents. 4. Resident #3 was admitted to the facility on 12/26/05 and readmitted 6/14/13. Diagnoses included anemia, heart failure, hypertension, dementia, anxiety and depression. The most recent Minimum Data Set (MDS), a quarterly assessment dated 6/7/13, indicated Resident #3 had severe cognitive impairment, sometimes was understood and sometimes understands, required extensive assistance of 1 person for transfers and toileting, and was occasionally incontinent of bowel and bladder. On 8/5/13 at 1:30 PM, two family members of Resident #3 stated that the resident had to wait 30 - 50 minutes for her call light to be answered after supper. They indicated that the resident was incontinent at times only because she had to wait so long for assistance. They also said they did the resident ' s laundry so they were aware of the frequency in which the resident had soaked through the incontinence product onto her clothing.	F 312		

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F 312	Continued From page 19 During an interview on 8/8/13 at 2:30 PM, Nursing Assistant (NA) #5 stated she frequently was assigned to Resident #3 on the 7-3 shift. NA #5 said she toileted the resident when getting her up and before and after meals. NA #5 said Resident #3 can also tell staff if she needed to use the toilet so the resident was not incontinent during the day. 5. Resident # 118 was admitted to facility 12/21/11. Cumulative diagnoses included: Degenerative Disc Disease and Congestive Heart Failure. A Quarterly Minimum Data Set (MDS) dated 6/1/13 indicated Resident # 118 was cognitively intact. Extensive assistance was needed with toileting and limited assistance with personal hygiene. During the assessment period, it was noted that Resident # 118 was frequently incontinent of bladder and bowel. A care plan dated 11/2011 and last reviewed 6/13 indicated Resident #118 was at risk for reduced physical function related to obesity, DM. Interventions included, in part, toilet on demand. Toilet q2hr (every two hours) at night was handwritten in on the care plan (no date when written). A Concern/ Grievance Reporting form dated 7/25/13 Resident # 118 was concerned that staff at night would not toilet her and didn ' t answer call bells timely. Follow-up action was to place resident on a every two hour (q2hr) toileting at night to ensure she was toileted. It was documented that Resident #118 was satisfied with that plan.	F 312		

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F 312	Continued From page 20 On 8/7/13 at 4:01 PM., an interview was conducted with Resident # 118. Resident #118 stated she wore pull-up briefs during the day and toileted/ changed her brief independently. After she went to bed around 8:00PM., she wore incontinent briefs and would need to receive incontinent care from the nursing staff. She indicated she did not have her incontinent brief changed until after 11:00 PM. Resident stated there were times she turned on the light, the nursing staff would come and turn the light off and say they would be back but they did not return. Resident # 118 indicated she got up around 9:00 AM. She would ring for toileting assistance in changing her incontinent brief in the morning and, at times, nursing staff would tell her that the food trays were being put on the hall and she would not been changed until after they had picked up the trays or received her bath for morning care. On 8/6/13 at 6:00PM., NA #1 stated there was one nursing assistant on the hall for the evening meal while the other was in the dining room. The one on the hall passed out the trays and fed the residents on the hall. When asked what she would do if someone wanted to be toileted or changed during the mealtime, NA #1 hesitated in answering, then said she would change them after the cart on the hall was gone off the hall. On 8/6/13 at 6:00 PM., Nurse #4 stated nursing staff did not change or toilet residents while the tray cart was on the hall. On 8/7/13 at 11:13 AM.; NA #2 stated she had always been told not to toilet or change anyone while the trays were out on the hall. If food was in the room for the resident who had requested to	F 312		

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F 312	Continued From page 21 have their incontinent brief changed or to be toileted or the roommate in the room, she would tell them she would toilet and/or change them after the trays were picked up. She said she tried to avoid that problem by asking and or changing residents prior to the meal so that would not happen. On 8/7/13 at 8:40 PM., Administrative staff #1 stated the person in charge on the 3-11 shift and 11-7 shift was the 200/300 hall nurse. Administrative staff #1 indicated that nursing staff can toilet residents or provide incontinent care during meals. She said there was one nursing assistant on the hall at meal time but the nurse assisted in answering call lights and any staff, even housekeeping, could find out what the resident needed. During meals, the nursing assistant would ask the roommate if the food tray could be removed during care and brought back afterwards. Administrative staff had no idea why some nursing staff would say they could not provide toileting/ incontinent care and she would need to in-service the staff.	F 312		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329	The medication for resident #4 was discontinued from the MAR and the computer on 08-07-13 prior to the surveyors exiting the facility. The MD was made aware of the medication being administered by the nurses after the order to discontinue the medication was in effect.. No additional orders were given. A medication Error report was completed. **Action taken regarding all others with the potential to be affected**	8/7/13

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 08/09/2013

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 329	Continued From page 22 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that residents were free from unnecessary medication as evidenced by administering the Zoloft (antidepressant)which was already discontinued for 1 (Resident #4) of 5 sampled residents. The findings included: Resident #4 was admitted to the facility on 5/9/11 with multiple diagnoses including depressive disorder. The nurse's notes were reviewed. The notes dated 5/27/13 at 2:40 PM revealed that Resident #4 had complained of dry mouth. The attending physician was informed with a new order to taper the Zoloft. The physician progress notes were reviewed. On 5/27/13, the notes revealed that Resident #4 had history of dry mouth and difficulty swallowing. Her medications were reviewed and have discussed the possibility of discontinuing some of her	F 329	A complete MAR and TAR audit was conducted for all current residents to determine accuracy of all orders to include those having a specific Stop Date. The audit consisted of a thorough reconciliation of the MARs and TARs to include review of all orders and a comparison of those orders to the MARs and TARs to ensure accuracy in transcription and processing. The audits were completed by the administrative nurses on or before 8/11/2013. No other resident was found to have had medications administered by the nurses after the order to discontinue the medication was in effect. **Measures put in place** All nurses will be educated by the SDC and the ADON on the proper way to discontinue and taper orders to include medications that indicate a specific Stop Date. The education included discontinuing medication in the electronic system. The education will also instruct nurses on how to identify and ensure accuracy of the new monthly MARs. This education will be completed by facility SDC and ADON by 08/30/2013 to allow for any staff on vacation.	8/11/13 8/30/13

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	345429	A. BUILDING _____ B. WING _____	C 08/09/2013

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 329	Continued From page 23 medications that might be causing the dry mouth. On 5/27/13, there was an order to "decrease the Zoloft to 100 milligrams (mgs) by mouth in the morning for 1 week and then decrease to 50 mgs by mouth in the morning for 1 week and then discontinue." The Medication Administration Records (MARs) were reviewed. The June, 2013 MAR revealed that Zoloft 100 mgs was given from 5/28- 6/3/13. Zoloft 50 mgs was administered from 6/4 - 6/10/13 and then it was discontinued. The July, 2013 did not include Zoloft on the list of medications. The MAR for August, 2013 revealed that Zoloft 100 mgs and Zoloft 50 mgs were transcribed to be given at 9:00 AM and were initialed as given from 8/1- 8/7/13. On 8/8/13 at 9:15 AM, Nurse #2 was interviewed. She stated that she was assigned to Resident #4 on 8/1, 8/3 and 8/4/13 on day shift. She indicated that her initial on the MAR would indicate that she had administered the medication (Zoloft 100 mgs and 50 mgs) on 8/1, 8/3 and 8/4/13 at 9:00 AM to Resident #4. On 8/9/13 at 7:58 AM, Nurse #3 was interviewed. She stated that she was assigned to Resident #4 on 8/2, 8/5 and 8/7/13 on day shift. She added that her initial on the MAR would indicate that she had administered the Zoloft 100 mgs and 50 mgs at 9:00 AM. On 8/9/13 at 8:05 AM, administrative staff #1 was interviewed. She stated that she was aware of the medication error on Resident #4. She added that the Zoloft was discontinued in June but was printed by the pharmacy on the August, 2013	F 329	**Monitoring** The facility has developed an audit tool to monitor for proper tapering and discontinuing orders from the MARs as well as the computer software. The audit tool consists of the following components: 1. did resident have any order changes in the last week; 2. Determine is the order was transcribed to the MAR correctly; and 3. Determine if the order was placed in the computer correctly. Each new monthly MAR will be reviewed by two nurses to ensure accuracy before the MAR is given to the floor nurse. 25% of charts will be audited weekly for two weeks, then 10% weekly for six weeks, then 10% of all new monthly MARs for six months to ensure continued compliance. These audits will be discussed weekly during the administrative nursing meeting. QA follow up will be reviewed during the next scheduled QA committee meeting. It was verified during the Administrative nurses meeting on 8-15 that SDC completed audits on 8-11, 8-12, 8-13, 8-14 and 8-15. The DON completed audits on 8-14. It was verified during the 8-20 Administrative nurses meeting that SDC completed audits on 8-18, the QA nurse completed audits on 8-18 and 8-19. During the 8-29 Administrative nurses meeting it was verified that QA nurse completed audits on 8-26 and it was verified during the Administrative nurses meeting held 9-8 that QA nurse completed audit on 9-3. Going forward the DON will assign audits to an administrative nurse during the weekly Administrative nurses meeting and this will be reflected in the meeting minutes.	8/11/13

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	345429	A. BUILDING _____ B. WING _____	C 08/09/2013

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 329	Continued From page 24 MAR. She acknowledged that 3 staff members who had checked the MAR had missed it.	F 329	The physician for resident #41 was notified of the medication errors. A medication error report was then completed. The attending physician did not give any orders regarding medication errors. The nurse involved was educated regarding the medication administration policy on 08/09/2013.	8/9/13
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that the medication error rate was 5% or below as evidenced by 3 errors (Resident #41) of 30 opportunities for error resulting to a 10% error rate. The findings included: 1a. Resident #41 was admitted to the facility on 1/22/13 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). The current physician's orders (August, 2013) revealed that Resident #41 had an order dated 1/30/13 for Flovent 2 puff twice a day for COPD. On 8/7/13 at 9:04 AM, Resident #41 was observed during the medication pass. Nurse #2 was observed to prepare and to administer the medications including Flovent 3 puffs. On 8/7/13 at 9:55 AM, Nurse #2 was interviewed. She stated that she was a floater and was not aware that the order for the Flovent was changed from 3 puffs to 2 puffs.	F 332	**Action taken regarding all others with the potential to be affected** Immediately following policy instruction provided to Nurse #2 by the SDC, a thorough medication administration observation was conducted by the SDC to ensure Nurse #2's understanding and compliance to policy. This observation consisted of viewing all forms of medication to include inhalers, eye drops, administering medications via G tubes. Wait times between eye drops and inhalers were also observed. No medication errors were identified during the observation. **Measures put in place** All nurses received education by the DON and SDC regarding medication administration policy by 9/6/2013. All nurses will in addition receive a medication administration observation on or before 8/30/2013 which will be conducted by the DON or an administrative nurse. No nurse was observed to have a 5% error rate or greater. Any nurse on vacation or leave will receive education before returning to work.	8/12/13 9/6/13

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F 332	Continued From page 25 1b. Resident #41 was admitted to the facility on 1/22/13 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). The current physician's orders (August, 2013) revealed that Resident #41 had an order dated 1/30/13 for Flovent 2 puff twice a day for COPD. On 8/7/13 at 9:04 AM, Resident #41 was observed during the medication pass. Nurse #2 was observed to prepare and to administer the medications including Flovent 3 puffs. The nurse was not observed to wait at least a minute between puffs. On 8/7/13 at 9:55 AM, Nurse #2 was interviewed. She stated that she was supposed to wait a minute between puffs and she thought she did but she did not have a watch to make sure it was a minute. 1c. Resident #41 was admitted to the facility on 1/22/13 with multiple diagnoses including Constipation The current physician's orders (August, 2013) revealed that Resident #41 had an order dated 1/30/13 for Metamucil 1 tablespoon daily for constipation. On 8/7/13 at 9:04 AM, Resident #41 was observed during the medication pass. Nurse #2 was observed to prepare and to administer the medications including Metamucil 5 teaspoons dissolved in 8 ounces (oz) of water. On 8/7/13 at 9:55 AM, Nurse #2 was interviewed.	F 332	**Monitoring** Monthly Medication Administration Observations will continue for the next three months and will include all observation of all nurses responsible for medication administration. The observations will be conducted by the SDC. The observation will include administering all types of medication to include eye drops, inhalers, administering medications via a g-tube, measuring medications of all types to include liquid and powder form and the practice of required wait times between medications such as inhalers and eye drops. Each medication administration observation will consist of 2 residents and at least 10 opportunities. The number of routes will be determined by what the resident's MAR indicates, however each administrative nurse conducting the observation will select residents that require the most varied routes so as to ensure the observation includes eye drops, crushed medication, liquid medications, inhalers and by mouth medications .The results from the medication administration observations will be discussed in the weekly administrative nursing meeting to determine the need for additional education and observations and all results will be assessed in the next QA meeting to ensure continued compliance. The initial med pass observations were completed by the SDC and DON. All future med pass audits needed will be conducted by the SDC.	9/6/13

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F 332	Continued From page 26 She acknowledged that she had administered 5 teaspoons of Metamucil because 1 tablespoon was equal to 5 teaspoons.	F 332	All dishware was examined for any stains cracks and other damage by the Dietary Manager. All items found to be compromised were immediately discarded and replaced 8/11/2013. All divided and undivided plates were replaced with new dishware.	8/9/13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to keep dishware free of debris and stains. The findings included: Observation of the kitchen's tray line on 08/07/13 at 5:21 PM revealed staff were in the process of plating resident evening meals. During this observation multiple dinner plates, that were ready for use, were heavily stained. One of these stained plates was observed to have a dried brown substance scattered on the plate's eating surface. The cook, who was placing food on plates for resident meals, was observed to pick up the unclean plate to place food on it when she was asked, by a surveyor, to examine the plate to determine if it should be used. The cook stated that the plate was just stained and was okay to use. The cook handed the plate to Dietary Manager (DM) #1 who acknowledged the plate	F 371	**Systemic Changes** The "Soaking Schedule" for glassware and dishware has been re-implemented which means that every dinnerware item will be soaked for at least an hour weekly to prevent staining. All dietary staff members were educated by the Dietary Manager on or before 8/12/2013 regarding proper handling of all dinnerware to include glassware, proper cleaning of all dinnerware to include glassware and the requirement to re-wash any item that is not free of debris. All dietary staff have been instructed to not use any dinnerware item that is not absolutely free of all debris. Any stained dinnerware or dinnerware containing debris will be taken out of service and the Dietary Manager will discard and reorder new dinnerware. Dishware surveillance and soaking schedule education was also provided. Any staff member on vacation or leave will receive education prior to returning to work.	8/12/13

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F 371	Continued From page 27 was stained and dirty and should not be used. Observations on 08/08/13 at 10:30 AM revealed 13 of 13 divided plates, stored in the kitchen and ready for use, were heavily stained. Two were also observed to have small areas of a foreign substance on their eating surface. During an interview on 8/8/13 at 10:30 AM, DM #2 acknowledged the two plates were dirty and added that all 13 plates were heavily stained and needed to be replaced.	F 371	**Monitoring** An inspection tracking form has been developed and implemented to validate inspection of all dishware and to verify that there is no presence of cracked, chipped, damaged or stained dinnerware. The form consists of daily entries by the first shift cook that determines inspection of all plates and dinnerware. This monitoring was conducted five times a week initially and was conducted by the Dietary Manager. Starting 8/31/2013 the First shift cook will be responsible for completion of the tracking form. This monitoring tool will be used for the next three months, and any additional monitoring will be determined by the results of the first three months of monitoring. **QA** Results of the monitoring will be reviewed and trended at the next scheduled QA committee meeting	8/31/13
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. The facility must provide separately locked,	F 431	The medication was disposed of properly by the DON after the surveyor presented it to her. **Action taken regarding all others with the potential to be affected**	8/9/13

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PEAK PESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

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F 431	Continued From page 28 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 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 observation, staff interview and review of facility policy, the facility failed to discard a single use vial of Haldol (an antipsychotic medication) after partial use on one of three medication carts (100 hall medication cart). The findings included: Facility policy titled "Preparation for Medication Administration" revised 11/1/2011 read, in part, "3c. Ampules and single-use vials (containing no preservatives) are discarded immediately after use." On 8/8/13 at 11:30 AM., the 100 medication cart was observed. One single-dose vial of Haldol was noted opened and undated. On 8/8/13 at 11:30 AM., Nurse #1 stated the medication must have been used last night when they received a new order for a resident to receive that medication. On 8/9/13 at 11:45 AM., Administrative staff #1 stated the single-dose vial of Haldol should have been discarded after use	F 431	All medication carts were inspected immediately by the ADON and MDS to determine compliance regarding proper disposal of medications protocol. **Measures put in place** All nurses were educated by the SDC on proper and timely disposal of single use vials and the facility's expectation of timely disposal being immediately and at time of use. This education was completed on or before 08/30/2013 to allow for any staff on vacation. **Monitoring** The facility has developed an audit tool to monitor for continued compliance. All carts will be audited daily for one week and then weekly for six weeks and then monthly for 4 months by the administrative nurses to ensure continued compliance. These audits will be reviewed weekly during the administrative nursing meeting and will be reviewed at the next scheduled QA committee meeting to ensure continued compliance. Assigned rounds will be given to each administrative nurse and at least weekly inspections of carts will continue for the next three months. These inspections will also be discussed at the next QA meeting. It was verified during the 8-15 Adminstrative nurses meeting that DON completed audits on 8-9, 8-10, 8-12, 8-13,8-14 8-15 and 8-16. The SDC completed the audits on 8-11. It was verified during the 8-20 Adminstrative nurses meeting that DON completed audits on 8-20. It was verified during the 8-29 Adminstrative nurses meeting that MDS nurse #1 completed audits on 8-25. It was verified during the 9-8 Administrative nurses meeting that MDS nurse #1 completed audits for 9-3. Going forward the DON will assign audits to the Administrative nurses during the weekly Administrative nurses meetings and this will be reflected in the meeting minutes.	8/30/13 8/9/13

Peak Resources-Pinelake shall continue to maintain resident safety by providing electromagnetic locks installed on egress doors to release on activation of the fire alarm panel.

The electromagnetic locks that were identified not to release on activation of fire alarm was repaired by ordering a circuit board on 8/30/2013 and upon arrival of the circuit board it was installed.

The doors going into the special care unit have been tested and are releasing on activation of fire alarm.

The Environmental Services Director will conduct monthly inspections regarding all electromagnetic locks installed on doors throughout the facility. In addition, Peak Resources-Pinelake will continue to ensure that annual fire inspections are conducted by an outside contractor to further ensure continued compliance.

Results of monthly inspections will be discussed in our monthly safety meeting. Any discrepancies will be discussed with the administrator immediately, and any necessary repairs will be completed immediately.

PRINTED: 08/30/2013
FORM APPROVED
OMB NO. 0938-0391

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

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	345429	A. BUILDING 01 - BUILDING 0101 B. WING	08/29/2013

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

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K 000	INITIAL COMMENTS Surveyor: 27871 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 construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Peak Resources-Pinelake shall continue to maintain resident safety by providing electromagnetic locks installed on egress doors to release on activation of the fire alarm panel. The electromagnetic locks that were identified not to release on activation of fire alarm was repaired by ordering a circuit board on 8/30/2013 and upon arrival of the circuit board it was installed. The doors going into the special care unit have been tested and are releasing on activation of fire alarm. The Environmental Services Director will conduct monthly inspections regarding all electromagnetic locks installed on doors throughout the facility. In addition, Peak Resources-Pinelake will continue to ensure that annual fire inspections are conducted by an outside contractor to further ensure continued compliance. Results of monthly inspections will be discussed in our monthly safety meeting. Any discrepancies will be discussed with the administrator immediately, and any necessary repairs will be completed immediately.	9/9/2013
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: the electromagnetic locks installed on doors going into special care unit and the exit egress door in unit, did not release on activation of fire alarm test(the on/off switch at nurse station and at doors released locks). 42 CFR 483.70(a)	K 038		

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

Bernard Byrd — Administrator — 9/11/13

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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	345429	A. BUILDING 02 - NEW REHAB ADDITION B. WING	08/29/2013

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

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K 000	INITIAL COMMENTS Surveyor: 27871 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 building is Type III construction, one story, with a complete automatic sprinkler system. Based on observations and staff interview at approximately 11:00 am, no LSC deficiencies were noted at time of survey.	K 000		

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

Administrator 9/11/13

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.