10/16/13

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 09/27/2013

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 000	INITIAL COMMENTS A revisit on a recertification and complaint investigation (Event ID# J3FE12) was done during this complaint investigation survey (Event ID# TTGY11). Tag F312 was recited. Tags F246 and F441 were also cited.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to place call bells within reach for 2 of 4 residents (Resident #4 and #8). Findings included: 1. Resident #4 was admitted to the facility on 5/9/11 with diagnoses that included lack of coordination, osteoarthritis, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated 9/13/13 indicated Resident #4 was cognitively intact, always incontinent of bladder, frequently incontinent of bowel, and needed extensive assistance with dressing, eating, bed mobility, transfers, locomotion on and	F 246	Resident #1 was assessed immediately by the SDC to ensure that all of her needs were being met at that time. It was determined by the SDC through her assessment that Resident #1's needs were being met at that present time. SDC ensured that call bell was in reach and that resident was aware of the location of the call bell. **Action taken regarding all others with the potential to be affected** All current residents were assessed on 9/27/2013 by the DON, ADON, SDC, MDS Nurse #1 and MDS Nurse #2 to ensure that all current needs were being accommodated at the time of the assessment and that the call bell was in reach so that each Resident had the ability to summons for help in case he or she did need something.	9/27/13 9/27/13

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

10/11/13

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.

✓ G.S. A.H. D.R.

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 09/27/2013

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 246	Continued From page 1 off the unit, toileting and personal hygiene. The care plan most recently updated September 2013 indicated the resident's ability to perform activities of daily living were impaired and she was at risk for falling related to impaired mobility, muscle weakness, and "not realizing limitations (attempting to get up without assistance)." Interventions included "Keep call light in reach at all times", "Give resident verbal reminders not to ambulate/transfer without assistance", and "Provide extensive assist in bed mobility, transfers and toileting." During an interview on 9/26/13 at 3:45 pm, Nurse Aide (NA) #2 stated, "We clip the call bells to the resident or bed so it will stay within reach. Even non oriented residents should have a call bell. If they are impaired and can't push the button they will have a touch pad to use." During an observation on 9/27/13 at 9:00 am, Resident #4 was sitting in her bed in a semi-upright position. Her call bell was observed lying on the floor, at the right side of her bed, next to her nightstand, and out of her reach. During an interview on 9/27/13 at 9:01 am, Resident #4 was asked about her call bell, if she had it, and if she could use it. Resident #4 stated, "I am lost without my call bell and I panic when I don't have it. I don't know where it is. When I do have it and push it, it all depends on who is working as to how quickly they help. I am very uncomfortable right now. I need to be readjusted in bed. I have been sitting like this for a while and I have a place on my hip that is very sore. That is why I need my call bell."	F 246	**Measures put in place** All staff will be educated on appropriate placement of call bells and the requirement that it be placed within reach of the Resident by 9/29/2013. Further education will continue to ensure that any staff on leave or vacation will receive education. The SDC has incorporated this new lesson plan into the orientation process so all new hires will receive this education as well. **Monitoring** An audit tool has been developed that will aid in effective monitoring. The DON has created a Resident Census Assignment Sheet in which each Administrative Nurses will be assigned to specific Residents. The DON, ADON, SDC, MDS Nurse #1, MDS Nurse #2, Weekend RN Supervisor #1 and Weekend RN Supervisor #2 will conduct audits in which residents will be observed over the course of all three shifts whereby all residents will be observed by 9/29/2013 to ensure proper call bell placement.	9/29/13 9/29/13

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 09/27/2013

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 246	Continued From page 2 During an interview on 9/27/13 at 9:10 am with Nurse #1, she indicated Resident #4's call bell was not within reach, was lying on the floor next to her nightstand, she was able to use her call bell, and it should be within her reach. She picked up the call bell and placed it within the resident's reach. During an observation on 9/27/13 at 10:15 am, Resident #4 was observed lying in bed asleep. The call bell was attached to the right corner of her bedspread and was approximately 6 inches off the floor. The call bell was not within her reach. During an interview on 9/27/13 at 11:51am, Resident #4 stated, "It happens pretty often - about 2 or 3 times a week - that someone will come in to change me or fix something with my bed, and the call bell is not left where I can reach it. It makes me feel helpless because if I needed something, I could not call for anyone. It is so necessary for me to have it when I can't walk or do for myself. Sometimes I just have to yell out for help because I don't have it." During an interview on 9/27/13 at 12:39 pm, the Director of Nursing indicated it was her expectation that a resident that is in her room and in her bed have a call bell within her reach. 2. Resident #8 was admitted to the facility on 5/16/13 with diagnoses that included urinary tract infection, hemiplegia, muscle weakness, lack of coordination, and stroke. The quarterly Minimum Data Set (MDS) assessment dated 8/23/13 indicated the resident participated in the assessment, had moderately	F 246	Thereafter, to ensure continued compliance monthly audits will be conducted to include at least ten percent of the Resident population each month for the next six months. All findings from the audits will be discussed in the weekly Standards of Care meeting. Quality Assurance All findings will be brought to the next scheduled QA meeting. Continued audits will be determined based on findings from audits.	

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 09/27/2013

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 246	Continued From page 3 impaired cognition for daily decision making, needed extensive assistance with toileting, personal hygiene, bed mobility, transfer, and dressing. She needed limited assistance with eating and locomotion on and off the unit in her wheelchair. The care plan most recently updated August 2013 indicated Resident #8 was at risk for falling related to poor cognition and impaired mobility. Interventions included, "Keep call light in reach at all times." During an interview on 9/26/13 at 3:45 pm, NA #2 stated, "We clip the call bells to the resident or bed so it will stay within reach. Even non-oriented residents should have a call bell. If they are impaired and can't push the button they will have a touch pad to use." During an observation on 9/27/13 at 9:08 am, Resident #8 was lying on her bed, flat on her back, with her head to the left side of the bed and both legs and feet hanging off the right side of the bed. There was no call bell within reach or within sight. During an interview on 9/27/13 at 9:10 am with Nurse #1, she indicated Resident #8's call bell was not within reach, was lying on the floor at the head of the bed next to the wall, she was able to use her call bell, and it should be within her reach. She picked up the call bell and placed it within the resident's reach. During an interview on 9/27/13 at 12:39 pm, the Director of Nursing indicated it was her expectation that a resident that is in her room and in her bed have a call bell within her reach.	F 246		

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 09/27/2013

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 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, record review, and interviews with residents and staff, the facility failed to provide incontinent care in a manner to maintain personal hygiene for 2 of 4 residents (Resident #8 and #4) who needed extensive assistance to total assistance with toileting/personal hygiene. Findings included: 1. Resident #8 was admitted to the facility on 5/16/13 with diagnoses that included urinary tract infection, hemiplegia, muscle weakness, lack of coordination, stroke. The care plan most recently updated on 8/15/13 indicated Resident #8 was at risk for pressure ulcers related to impaired mobility and incontinence. Approaches included, "Provide incontinent care after each incontinent episode. Avoid friction to skin." The quarterly Minimum Data Set (MDS) assessment dated 8/23/13 indicated the resident had moderately impaired cognition for daily decision making, was always incontinent of bladder and bowel, and needed extensive assistance with toileting and personal hygiene.	F 312	Resident #4 and Resident #8 were assessed by the SDC to ensure that there were no negative outcomes as a result of the incontinence care that was provided by C.N.A. #1 on 9/27/2013. The SDC provided immediate education to C.N.A. #1 regarding the Incontinence Care Policy and Procedure. Through a complete nursing assessment by the SDC, it was determined that there were no negative outcomes as a result of the incontinence care provided. Immediately following the SDC's assessment, a bed bath was provided by the SDC to both Resident #1 and Resident #2 to ensure proper hygiene was provided for both residents. **Action taken regarding all others with the potential to be affected** All current residents identified by nursing as needing routine incontinence care were assessed by 9/29/2013 by the DON, ADON, SDC, MDS Nurse #1 and MDS #2 to ensure that each Resident was receiving incontinence care as indicated by the facility's Policies and Procedures regarding Incontinence Care. Based on the assessments, no issues related to Incontinence Care were identified by any nurse conducting the assessments.	9/27/13 9/29/13

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 09/27/2013

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 312	Continued From page 5 On 9/27/13 at 9:23 am, urinary incontinent care was observed being provided to Resident #8 while she was standing and holding onto the grab bar in the bathroom. NA #1 obtained supplies to provide care, filled the wash basin that was sitting in the sink with water. The NA used a wet washcloth with soap to clean the perineal area. She used a continuous front to back to front wiping motion to the perineal area without picking up the cloth from the perineal area. She used the same cloth and wiped the rectal area with the same back and forth motion wiping motion, without picking up the cloth from the rectal area. NA #1 placed the cloth used to clean the perineal and rectal area in the basin of water, took a second wash cloth, placed it in the basin of water, and used the second washcloth to rinse the perineal and rectal area with the dirty water. During an interview on 9/27/13 at 9:43 am, regarding the incontinent care provided to Resident #8, NA #1 indicated she should have used clean water to rinse the resident after providing care and wiping should be a front to back motion. The Incontinent Care in-service staff roster dated 8/29/13 indicated Nurse Aide #1 was in-serviced that day on Incontinent Care. During an interview on 9/27/13 at 12:35 pm, the Staff Development Coordinator indicated she completed the Incontinent Care in-service training with staff, that NA #1 had been called and completed the in-service over the phone, and she (SDC) had written NA #1's name on the in-service roster.	F 312	**Measures put in place** A Lesson Plan was developed for Incontinence/Perennial Care with the following objectives being 1. ADL care being carried out as necessary to maintain each Resident at the highest practicable level, 2. The assurance that staff provide cleanliness and comfort to each Resident, while preventing infections and skin irritation, and observing Resident's skin condition, and 3. Staff's understanding of the concept of cross contamination. The mode of Presentation is through lecture, observation and return demonstration. The inservice education will be provided by the SDC, DON, ADON, MDS Nurse #1, MDS Nurse #2, Weekend RN #1 Supervisor Weekend RN Supervisor#2. All staff will receive education by 9/29/2013, and further education will be provided to ensure education of staff that are on leave or vacation. This lesson plan will be incorporated into our orientation process so that all new hires are education as well.	9/29/13

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 09/27/2013

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 312	Continued From page 6 During an interview on 9/27/13 at 12:39 pm, the Director of Nursing (DON) indicated when incontinent care is provided, wiping should be a front to back motion, two washcloths should be used, and clean water should be used to rinse. 2. Resident #4 was admitted to the facility on 5/9/11 with diagnoses that included lack of coordination, osteoarthritis, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated 9/13/13 indicated Resident #4 was cognitively intact, always incontinent of bladder, frequently incontinent of bowel, and needed extensive assistance with toileting and personal hygiene. On 9/27/13 at 9:35 am, urinary incontinent care was observed being provided to Resident #4 while in her bed. NA #1 obtained supplies to provide care, filled the wash basin with water, positioned the resident on her right side, and removed the resident ' s adult incontinent brief. The NA used a wet washcloth with soap to clean the perineal area. She used a continuous front to back to front wiping motion to the perineal area without picking up the cloth from the perineal area. She did not separate the labia and wash downward. She did not move from the inside outward to and including the thighs. She did not rinse the cloth, but turned it over and used the opposite side of the same cloth to rinse the resident. She rinsed the cloth in the basin, washed the rectal area, which revealed a moderate amount of brown residue covering the cloth, folded the washcloth and rinsed the rectal area with the same cloth.	F 312	**Monitoring** An audit tool has been developed that will aid in effective monitoring. The audit tool consists of questions that relate to incontinence care, such as 1. Did the auditor observe incontinent care, 2. Was incontinent care provided according to policy,3. Has the employee been educated on appropriate incontinent care and was the facility's infection control policy followed. The DON has created a Resident Census Assignment Sheet in which each Administrative Nurses will be assigned to specific Residents. The DON, ADON, SDC, MDS Nurse #1, MDS Nurse #2, Weekend RN Supervisor #1 and Weekend RN Supervisor #2 will conduct audits in which residents will be observed over the course of all three shifts and whereby each Resident identified by nursing to require routine incontinence care will be observed receiving incontinence care by 10/27/2013. Thereafter, to ensure continued compliance with our incontinence policies and procedures monthly audits will be conducted to include at least ten percent of the Resident population each month for	

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 09/27/2013

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 312	Continued From page 7 During an interview on 9/27/13 at 9:43 am, regarding the incontinent care provided to Resident #4, NA #1 stated, "One side of cloth was dirty. I turned the same cloth over and used the other side of the same cloth to rinse." She indicated she should have used a second washcloth to rinse. The Incontinent Care in-service staff roster dated 8/29/13 indicated Nurse Aide #1 was in-serviced that day on Incontinent Care. During an interview on 9/27/13 at 12:35 pm, the Staff Development Coordinator indicated she completed the Incontinent Care in-service training with staff, that NA #1 had been called and completed the in-service over the phone, and she (SDC) had written NA #1's name on the in-service roster. During an interview on 9/27/13 at 12:39 pm, the Director of Nursing (DON) indicated when incontinent care is provided, wiping should be a front to back motion, two washcloths should be used, and clean water should be used to rinse.	F 312	the next six months. All findings from the audits will be discussed in the weekly Standards of Care meeting. In addition, all C.N.A.s will receive Skills Check Assessment which will be completed by one of the above mentioned Administrative nurses beginning 9/27/2013 with 100 % completion of all C.N.A staff by 10/27/2013. **Quality Assurance** All findings will be brought to the next scheduled QA meeting. Continued audits will be determined based on findings from audits.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441	Resident #4 and her surroundings were immediately assessed by the SDC to ensure that there were no issues related to the facility's infection control program that had not been addressed. The SDC provided immediate education to C.N.A.#1	9/27/13

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 09/27/2013

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 441	Continued From page 8 (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with staff, the facility failed to follow infection control practices, to prevent cross contamination, while providing care for 1 of 4 residents (Resident #4). Findings included: The Handwashing/Hand Hygiene policy dated	F 441	regarding Infection Control Policy and Procedures and the facility's expectations and requirements from its staff as related to its Infection Control Program. Upon the SDC's assessment of Resident#4, no violations of the facility's Infection Control Policies and Procedures were identified. **Action taken regarding all others with the potential to be affected** All current residents and their surroundings were assessed on 9/27/2013 by the DON, ADON, SDC, MDS nurse#1 and MDS nurse#2 to ensure that there were no issues related to the facility's Infection Control Program and that the staff members were following the Infection Control Policies and Procedures. Based on the assessments, no issues related to the Infection Control Program were identified by any nurse conducting the assessments. **Measures put in place** A Lesson Plan was developed titled Infection Control: Preventing the Spread of Infection, with the Objective being: To Prevent the Spread of Infection for All Staff to be able to verbalize how to prevent the spread of infection. The mode of presentation for this lesson plan will be through 1. Demonstration, 2. Lecture, and 3. Post Test. The target audience will be ALL STAFF, to include	9/27/13

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 09/27/2013

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 441	Continued From page 9 March 2003 stated, "Handwashing/Hand hygiene is regarded by this facility as the single most important means of preventing the spread of infections." It further indicated that employees must perform handwashing after contact with body fluids, secretions, and mucous membranes or after handling items potentially contaminated with body fluids, or secretions. On 9/27/13 at 9:35 am, urinary incontinent care was observed being provided to Resident #4 while in her bed. Nurse Aide (NA) #1 placed a plastic bag, laid open, on the resident's bedspread. When positioning the resident to provide care and moving the resident's linens, the corded bed remote became positioned on top of the opening of the plastic bag. While providing care, the wet incontinent brief was placed at the opening of the plastic bag, on top of the remote. NA #1, using her gloved left hand, washed the resident ' s rectal area, which revealed a moderate amount of brown residue covering the cloth, folded the washcloth and rinsed the rectal area with the same cloth. The used washcloth was placed in the plastic bag with the wet incontinent brief and corded bed remote. After providing care, NA #1 did not remove her gloves, picked up the plastic bag, used her still-gloved left hand to remove the bed remote from the bag, and laid the bed remote on the resident ' s bedspread. NA #1 placed the plastic bag on the floor, cleaned up the supplies, removed her gloves, washed her hands, straightened the resident's sheet and bedspread, picked up the contaminated bed remote with her ungloved hand and placed it on top of the bedspread. NA #1 picked up the plastic bag and walked to the hallway.	F 441	Rehab, Nursing, Housekeeping, Laundry, Environmental Services and Dietary. All staff will be required to complete a Post Test on Cross Contamination. Any employee that does not answer all questions correctly will be required to go through additional training and complete all components of the lesson plan again to include re-taking the post-test on cross contamination. The inservice education will be provided by the SDC, DON, ADON, MDS Nurse #1, MDS Nurse #2 and Weekend Supervisor #1 and Weekend Supervisor #2. All staff will receive education by 9/29/2013, and further education will be provided to ensure staff on leave or vacation are educated as well. The lesson plan will be incorporated into our orientation for all newly hired C.N.A.s and nurses. **Monitoring** An audit tool has been developed that will aid in effective monitoring. The audit tool consists of questions that relate to Infection Control and Cross Contamination in regard to not only each perspective resident, but to his or her surroundings. The DON has created a Resident Census Assignment Sheet in which each Administrative	9/29/13

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 09/27/2013

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 441	Continued From page 10 During an interview on 9/27/13 at 9:43 am, NA #1 indicated she had completed care for Resident #4 and, after disposing of the plastic bag, would be going to provide care to another resident. When asked if the corded bed remote and her ungloved hands were potentially contaminated, and could be a source of cross contamination, she stated, "Yeah, I guess I will need to clean that off." She put on gloves and cleaned the bed remote with soap and water. During an interview on 9/27/13 at 12:39 pm, the Director of Nursing (DON) indicated when incontinent care was provided, staff should follow the Handwashing/Hand Hygiene policy to prevent cross contamination.	F 441	Nurse will be assigned to specific Residents. The DON, ADON, SDC, MDS Nurse #1, MDS Nurse #2, Weekend RN Supervisor #1 and Weekend RN supervisor #2 will conduct audits in which residents will be observed over the course of all three shifts whereby all residents will be observed by 10/27/2013. Thereafter, to ensure continued compliance monthly audits will be conducted to include at least ten percent of the Resident population each month for the next six months. All findings from audits will be discussed in the weekly Standards of Care meeting. **Quality Assurance** All findings will be brought to the next scheduled QA meeting. Continued audits will be determined based on findings from audits.	