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 07/28/2016

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 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interview, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of dialysis (Resident #154), cognition (Resident #39) and psychotropic medications (Resident #89, #99) for four of twenty sampled	F 278	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to	8/12/16

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

Electronically Signed | 08/12/2016

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F 278	Continued From page 1 residents whose assessment was reviewed. The findings included: 1. Resident #154 was admitted to the facility 7/5/16. Cumulative diagnoses included end stage renal disease. The Resident received hemodialysis on Monday, Wednesday and Friday. An Admission Minimum Data Set (MDS) dated 7/12/16 indicated Resident #154 was cognitively intact. End stage renal disease was noted as an active diagnosis. Under section O (special treatments, procedures and programs), dialysis was not checked as having been received during the fourteen day look back period. On 07/26/2016 2:36:31 PM, an interview was conducted with the MDS Nurse #1 who stated she completed the top section of "O" which was for special treatment/ procedures. She stated she obtained the information from the Medication Administration Record (MAR) that Resident #154 was on dialysis. She stated she would check the transportation log to determine the days that Resident #154 received dialysis and Resident #154 received dialysis on 7/6/16, 7/8/16 and 7/11/16. She said Resident #154 received dialysis three days during the look back period and she just missed it. 2. a. Resident #39 was admitted to the facility on 4/16/15 and re-entered the facility on 5/7/16. Cumulative diagnoses included cerebrovascular disease and hemiparesis (loss of use of one side of the body) affecting left non-dominant side. On 7/25/16 at 4:47PM, an interview was conducted with Resident #39 to determine if she would be able to complete a resident interview	F 278	Provide high quality care. F278 Residents # 154, # 39, #89 and #99 did not Experience any adverse effect related to MDS (Minimum Data Set) coding Inaccuracy. MDS assessments for all residents cited In the letter of deficiencies were modified for Accurate coding and resubmitted by the MDS coordinator by 8/10/16. Residents with potential. The following was accomplished: 1.All residents on dialysis, on antidepressants and who have impaired cognition had their Minimum Data Set reviewed for accuracy by the MDS coordinator by 8/10/16. No modifications were required. Measures put in place: 1.The Social worker and the MDS team, which consists of two MDS coordinators (which will be named MDS #1 and MDS#2) will be educated regarding the assessments process and coding the MDS accurately by the MDS corporate RN by: 08/12/2016 2. MDS assessments will be audited by the Director of Nursing for accurate coding. 3.Audit tools were developed, which	

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F 278	Continued From page 2 about the facility. Resident #39 was unable to tell me her location, the year, the month or what she had eaten for lunch that day. An Admission Minimum Data Set (MDS) dated 5/14/16 was reviewed. Under section C titled "Brief Interview for Mental Status (BIMS)", Resident #39 was coded as cognitively intact with a score of "15" . A review of the observation record dated 5/14/16 completed by the social worker revealed Resident #39 was severely impaired in cognition with a score of "6" . On 7/27/2016 at 4:10PM, an interview was conducted with the social worker. She stated she was responsible for completing section C. The social worker stated she completed an observation report and completed the resident interview by asking the questions that were noted in section C. She then coded the MDS from the questions that she asked the resident at that time. She reviewed the observation record dated 5/14/16 and stated she did not know why she coded Resident #39 as cognitively intact and should have caught that error. b. Resident #39 was admitted to the facility on 4/16/15 and re-entered the facility on 5/7/16. Cumulative diagnoses included cerebrovascular disease and hemiparesis (loss of use of one side of the body) affecting left non-dominant side. An unscheduled MDS dated 5/28/16 was reviewed. Under section C titled "Brief Interview for Mental Status (BIMS)" , Resident #39 was coded as cognitively intact with a score of "15" .	F 278	includes residents names, antidepressant medication, dialysis and impaired cognition, and will be used to complete audits of MDS assessments to verify that antidepressants, dialysis and cognition are coded accurately on the MDS. Monitoring: 20% of all new resident assessments will be audited for accurate coding of dialysis, antidepressant use and cognitive status, weekly for 8 weeks, then 10% weekly x 4 weeks. The results of the audits will determine the need for more frequent monitoring. QA: All audit information will be analyzed and reviewed by the Director of Nursing at the QA Committee meeting.	

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A review of the observation record dated 5/21/16 completed by the social worker revealed Resident #39 was severely impaired in cognition with a score of "6".

On 7/27/2016 at 4:10PM, an interview was conducted with the social worker. She stated she was responsible for completing section C. The social worker stated she completed an observation report and completed the resident interview by asking the questions that were noted in section C. She then coded the MDS from the questions that she asked the resident at that time. She reviewed the observation record dated 5/21/16 and stated she did not know why she coded Resident #39 as cognitively intact and should have caught that error.

3. Resident #89 was admitted to the facility on 12/10/15 with multiple diagnoses including anxiety disorder and failure to thrive. The quarterly Minimum Data Set (MDS) assessment dated 4/26/16 indicated that Resident # 89 had received an antidepressant medications six times during the last 7 days.
The Medication Administration Records (MARs) for Resident #89 were reviewed. The MARs revealed that the resident had received Remeron (antidepressant drug) 4 times during the look back period instead of 6 times.

On 7/26/16 at 9:05 AM, MDS Nurse #2 was interviewed. The MDS Nurse has reviewed the April 2016 MARs and the MDS assessment dated 4/26/16 and stated that she had coded the antidepressant medication wrong, it should have been coded as 4 instead of 6.

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On 7/27/16 at 12:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to code the MDS assessments accurately.

4. Resident #99 was admitted to the facility on 4/4/16 with multiple diagnoses that included depression.

A physician's order dated 5/17/16 indicated Resident #99 was ordered Celexa (antidepressant medication) 10 milligrams once daily.

A quarterly Minimum Data Set (MDS) assessment dated 7/11/16 indicated Resident #99 had significant cognitive impairment. The Medications Section of the 7/11/16 MDS indicated Resident #99 received antidepressant medication on zero days during the seven day look back period.

A review of Resident #99's July 2016 Medication Administration Record (MAR) for the 7/11/16 look back period revealed Resident #99 received Celexa on seven of seven days during the look back period.

An interview was conducted with the Director of Nursing on 7/27/16 at 12:55 PM. She indicated her expectation was for the MDS to be coded accurately.

An interview was conducted with MDS Nurse #2 on 7/27/16 at 4:25 PM. She stated she was responsible for completing the Medications Section of the MDS. The 7/11/16 MDS for Resident #99 was reviewed with MDS Nurse #2. The MAR that indicated Resident #99 received

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F 278	Continued From page 5 Celexa on seven days during the look back period of the 7/11/16 MDS was reviewed with MDS Nurse #2. She indicated the MDS was coded incorrectly. She stated she was going to complete a modification.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility to develop a care plan for one of two residents reviewed for range of motion and contractures who had contractures of her left hand and fingers (Resident #39), failed to include pain management in the plan of care for a	F 279	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to	8/10/16

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F 279	Continued From page 6 resident with a diagnosis of chronic pain who received narcotic pain medication routinely and as needed for one of two residents reviewed for pain management (Resident #100) and failed to develop a care plan for psychotropic medications for one of five residents reviewed for unnecessary medications (Resident #89). The findings included: 1. Resident #39 was admitted to the facility 4/16/15 and last readmitted to the facility on 5/7/16. Cumulative diagnoses included cerebrovascular accident (CVA) and hemiparesis (loss of use of one side of the body) affecting left non-dominant side. An Admission Minimum Data Set dated 5/14/16 indicated Resident #39 was cognitively intact. Resident #39 required extensive assistance with bed mobility, personal hygiene and locomotion on and off the unit. Total dependence was needed with transfers and bathing. Limitation in range of motion was noted for one side of her upper and lower extremities. An Occupational Therapy discharge summary dated 6/2/16 indicated occupational therapy was discontinued on 5/27/16 and stated Resident #39 tolerated wearing a left hand splint 4-6 hours per day and care giver education was completed for the wearing and care of splint. A FMP (functional maintenance plan) was established for splinting, positioning and exercise. Discharge disposition indicated "nursing--restorative nursing". A care plan dated 7/27/15 and last edited on 5/27/16 stated Resident #39 was at risk for poor hygiene related to impaired mobility. Interventions included, in part, to follow physical	F 279	Provide high quality care. F279 Residents #39, #100 and #89 did not experience any adverse effects related to care plan Inaccuracy. Resident #100 and #89 in the statement deficiencies had their care plan corrected by the MDS coordinator on 7-29-16. Resident #39 was referred to therapy on 7-28-16 and care plan will be updated with therapy recommendations when resident #39 is discharged from therapy. Residents with potential The following was accomplished: 1.100% of residents care plans were audited by MDS nurse #1 and MDS nurse #2 to see if a care plan was needed for Pain, antidepressant medications and Splints on 8-8-16. 2.MDS Nurse #1 and MDS nurse #2 have updated all care plans that needed care plans for Pain, antidepressant medications and Splints On 8-8-16. Audit results showed that all splint careplans were current, three resident's pain careplans were update and all antidepressants careplans were current. Measures put in place: 1.Corporate MDS consultant in-serviced MDS nurses (MDS Nurse 1 and MDS Nurse 2)on proper procedure for care planning and the importance of being 100% accurate with the care plan.	

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F 279	Continued From page 7 therapy, occupational therapy and speech therapy recommendations. There was not a care plan for splint use. On 7/28/2016 at 9:21AM, an interview was conducted with the Director of Nursing. She stated if a splint was used for any resident, she expected a care plan to be written for the use/ care of the splint. 2. Resident #100 was initially admitted to the facility on 7/8/14 and was most recently readmitted on 4/16/16. Her cumulative diagnoses included chronic pain and chronic back pain. The physician's orders for Resident #100 were reviewed. The orders included Morphine Extended Release (narcotic pain medication) 15 milligrams (mg) every 8 hours for chronic pain, Neurontin (pain medication) 800mg three times a day for chronic pain, Norco (narcotic pain medication) 5-325mg every 6 hours as needed (PRN) for breakthrough pain, and Ultram (narcotic pain medication) 50mg every 8 hours PRN for breakthrough pain. The quarterly Minimum Data Set (MDS) assessment dated 4/25/16 indicated Resident #100 was cognitively intact. She was indicated to have received scheduled pain medications during the review period. Resident #100 had not received PRN pain medications or non-medication interventions for pain during the review period. During the resident pain assessment interview, Resident #100 indicated she had pain during the review period, she indicated the frequency of her pain was rarely, and she rated her worst pain intensity during the review period as a 2 on a scale of 1-10.	F 279	Completed on 8-10-16 2.An audit tool was developed and will be used by the DON (Director of Nursing) for care plan accuracy for Pain, psychotropic medications and splints. The audit tool includes residents' names and identifies whether they are receiving antidepressant medications, pain medications or are utilizing splints. Care plans will be addressed as indicated. Monitoring: 20% of all resident Care plans will be audited for accuracy for residents with pain, who receive antidepressant medication and who have splints, weekly for 5 weeks, then 10% weekly for 5 weeks. Audits will continue quarterly and the results will determine the need for more frequent monitoring. QA: All audit information will be brought to the QA meeting monthly by DON to be analyzed and reviewed by the QA Committee meeting.	

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A review of Resident #100's May 2016 Medication Administration Record (MAR) revealed she was administered PRN Norco seven times during the month of May. Resident #100 ' s pain intensity rating ranged from a 4 out of 10 to a 9.5 out of 10. All administrations were indicated as effective.

A review of Resident #100 ' s June 2016 MAR revealed she was administered PRN Norco seven times and PRN Ultram one time during the month June. Resident #100 ' s pain intensity rating ranged from a 4 out of 10 to an 8 out of 10. All administrations were indicated as effective.

A review of Resident #100 ' s July 2016 MAR revealed she was administered PRN Norco eight times and PRN Ultram one time during the month of July. Resident #100 ' s pain intensity rating ranged from a 5 out of 10 to a 9 out of 10. All administrations were indicated as effective.

Resident #100's comprehensive plan of care, with a reviewed/revised date of 7/18/16, was reviewed. There was no plan of care for pain management. The plan of care included the problem area of "Restorative [Active Range of Motion (AROM)] for Impaired Mobility". This problem area included the intervention, "report any pain noted to nurse". There was no other reference to Resident #100's pain in the comprehensive plan of care.

An interview with Resident #100 was conducted on 7/25/16 at 3:54 PM. Resident #100 indicated she had pain on the left side of her body. She indicated she received pain medications, but they had not fully relieved the pain. She stated the

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physician was aware of her ongoing pain.

An interview was conducted with MDS Nurse #2 on 7/27/16 at 4:25 PM. She stated she was responsible for completing plans of care related to pain management. She indicated that a plan of care for pain management was created if a resident ' s pain was not controlled with routine medication. The pain medications for Resident #100 were reviewed with MDS Nurse #2. She indicated if the PRN pain medications were administered for breakthrough pain then a plan of care for pain management should have been created. She stated if the PRN pain medications were not utilized, then a plan of care for pain management would probably not have been created. The administrations of the PRN Norco and Ultram for Resident #100 from 5/1/16 through 7/27/16 was reviewed with MDS Nurse #2. She indicated that due to the utilization of the PRN pain medications that Resident #100 should have had a plan of care for pain management.

A follow up interview was conducted with MDS Nurse #2 on 7/27/16 at 4:35 PM. She indicated she reviewed the plan of care for Resident #100. She stated the only reference to pain in Resident #100's plan of care was under the problem area of "Restorative AROM for Impaired Mobility". She indicated the intervention for this problem area included reporting any pain noted to the nurse. MDS Nurse #2 stated there was no plan of care for pain management for Resident #100.

A follow up interview with Resident #100 was conducted on 7/28/16 at 8:35 AM. She indicated she had pain from her head to her toe on the left side of her body. She stated she had her morning medications and they had helped to

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relieve some of her pain. She indicated her pain level had not affected her activity level as she spent most of the time in her room. She stated that it hurt to move, but she still moved when she needed to do so. She indicated the nurse asked her what her pain level was every time she was administered medication.

An interview was conducted with Nurse #3 on 7/28/16 at 9:10 AM. She indicated Resident #100 had some breakthrough pain that required the utilization of the PRN pain medications, Norco and Ultram, for pain management. She stated that Resident #100 was capable of self-reporting her pain. She indicated the PRN pain medications were effective for Resident #100.

An interview was conducted with the Director of Nursing (DON) on 7/28/16 at 9:30 AM. She indicated that a plan of care for pain management was expected to be created for a resident who had pain that was not controlled with scheduled medications. The pain medications for Resident #100 were reviewed with the DON. The PRN administrations of Norco and Ultram to Resident #100 from 5/1/16 through 7/27/16 were reviewed with the DON. She indicated that a plan of care for pain management should have been created for Resident #100 due to the chronic pain, routine morphine, and the use of the PRN Norco and Ultram. Resident #100's plan of care for the problem area of restorative AROM for impaired mobility was the reviewed with the DON. She indicated that had not met her expectations for a plan of care for pain management.

3. Resident #89 was admitted to the facility on 12/10/15 with multiple diagnoses including anxiety disorder and failure to thrive. The

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F 279	Continued From page 11 quarterly Minimum Data Set (MDS) assessment dated 4/26/16 indicated that Resident # 89 had received antianxiety and antidepressant medications during the last 7 days. The doctor's orders for Resident #89 were reviewed. The orders included Remeron (antidepressant drug) 7.5 milligrams (mgs) 1 tablet by mouth daily for appetite stimulant, started on 12/28/15 and Xanax (antianxiety drug) 0.25 mgs by mouth once a day for anxiety, started on 12/29/15. The Medication Administration Records (MARs) for Resident #89 were reviewed. The MARs revealed that the resident had received Xanax and Remeron from December 2015 to the present time. The current care plan was reviewed. There was no care plan developed to address the use of the Xanax and Remeron. On 7/26/16 at 9:05 AM, MDS Nurse #2 was interviewed. She stated that Resident #89 was started on Xanax and Remeron after admission to the facility. The MDS Nurse added that she failed to develop a care plan after she was made aware that the resident was started on psychotropic medications. On 7/27/16 at 12:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected the MDS Nurse to develop a care plan when a resident was on a psychotropic medication.	F 279		
F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO	F 280		8/17/16

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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 280 SS=D	Continued From page 12 PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record review the facility failed to involve cognitively intact residents and the Responsible Party in the care planning process for 2 of 2 sampled residents (Resident #19 and Resident #2) reviewed for participation in care planning. The findings included: 1. Resident #19 was admitted 2/25/13 and readmitted 2/23/15. She had cumulative diagnoses including heart failure, peripheral vascular disease and anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment dated 6/2/16 revealed resident #19	F 280	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact Exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F280 Residents #19 and #2 did not experience any adverse effects related to them not attending their care plan meeting.	

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F 280	Continued From page 13 was cognitively intact. The most recent care plan review date was 6/24/16. Review of the Care Conference Information in the medical record for the period 12/1/15 - 7/26/16 revealed documentation of a care conference on 1/20/16 with Resident #19 listed as one of the attendees. There was also a 4/14/16 Social Worker note indicating that a care plan notice was sent to the Responsible Party. The resident was not mentioned as being invited. There were no other care conferences or invitations documented for Resident #19 during this period. Resident #19 was interviewed on 7/26/16 at 9:30 AM. When asked if she was included in decisions about her medicine, care and treatment she stated she was not and also indicated that she had not been invited to care plan conferences. On 7/26/16 at 3:00 PM the Social Worker (SW) was interviewed. She stated that she started at the facility in April 2016. The Social Worker indicated that she was able to print a ' care conference due date ' report monthly and that she used this report to schedule care conferences and send invitation letters to the Responsible Party. The Social Worker then printed off several ' care conference due date ' reports as an example. In reviewing the example reports the SW was able to determine that if a care plan conference did not get documented in the system, the due date for the next care conference would not be created. As a result, the resident ' s future care conferences would be lost from the system and therefore potentially not occur. She further determined that for Resident #19 there had been a care conference due on 4/19/16 but there was no documentation indicating that the care conference took place. The Social Worker added that because Resident	F 280	Resident #19 had a care conference in her room on 4-26-16 and a late entry was put in on 7-27-16. Resident #2 had a care conference in her room on 7-29-16. Residents with potential The following was accomplished: 1.Social Worker audited 100% of the residents' electronic chart by 8/17/16 to compare it to the MDS (Minimum Data Set) calendar for the months of May, June and July to ensure that all residents had care conferences. No additional care conferences were required. Measures put in place: 1.Social Worker was in serviced on 7/29/16 by the administrator on Peak Resources INC policy, to verbally invite 100% of all residents to their care conferences and to document the invitation in the EHR (Electronic Health Record). 2.Social Worker will pull the care conference meetings report from Matrix and compare that list to the MDS assessment calendar for accuracy on an ongoing basis. 3.Resident invitation and attendance to the care plan meeting will be documented in the Social Workers care conference note. 4.An audit tool will be utilized to ensure that careplan meetings have been	

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F 280	Continued From page 14 #19's April 2016 care conference was not documented, the next conference due date had not changed and still read 4/19/16. The SW said that if the resident's April care plan conference had been held and documented, the next conference due date for Resident #19 would have been about 7/19/16 (90 days after the previous care conference). The SW added that at the end of June 2016 she printed a ' care conference due ' report for the month of July 2016 and Resident #19 was not listed. The SW acknowledged that she did not invite Resident #19 and the Responsible Party to a care conference in July and had not been aware that the care conference had been missed. On 7/27/16 at 10:30 AM the Director of Nursing was interviewed. She stated that she expected care plan conferences to occur according to the MDS schedule and that residents who could participate and the Responsible Party should be involved in planning care and invited to care conferences. On 7/27/16 at 4:00 PM, interview with MDS Coordinator #2 revealed that care conference meetings were supposed to be scheduled according to the MDS calendar for Comprehensive and Quarterly assessments. She added that using the MDS Calendar would resolve the issue of care conferences not occurring due to previously undocumented care conferences. MDS Coordinator #2 said she recalled a care conference with Resident #19 in April 2016. She also acknowledged there had not been a care conference that Resident #19 and the Responsible Party would have received an invitation for since April 2016. The most recent MDS assessment for Resident #19 was 6/2/16 and the most recent care plan review date was 6/24/16.	F 280	scheduled according to the MDS assessment calendar and invitations to careplan meetings have been documented in the EHR (Electronic Health Record). Monitoring: An audit will be conducted by the MDS nurses to ensure that 100% of careplan meetings have been scheduled by comparing the MDS calendar to the Careplan calendar and observing resident invitations documented in the EHR (Electronic Health Record). If the resident does not attend and is alert and oriented, the MDS nurse will interview the resident and ask if they were invited to the care plan meeting, weekly for three months, monthly for three months and quarterly thereafter. QA: All audit information will be brought to the QA meeting monthly by MDS nurses to be analyzed and reviewed by the DON at the QA Committee meeting.	

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F 280	Continued From page 15	F 280		

2. Resident #2 was originally admitted to the facility on 12/26/13. The annual Minimum Data Set (MDS) assessment dated 7/12/16 indicated that the resident's cognition was intact with the Brief Interview for Mental Status (BIMS) score of 14.

On 7/25/16 at 3:38 PM, Resident #2 was interviewed. Resident #2 stated that she was invited one time to the care plan meeting since she was admitted to the facility.

Review of the MDS assessments revealed that Resident #2 had assessments completed on 1/12/16, 4/13/16 and 7/12/16.

The social services notes were reviewed. The notes revealed that a care plan letter was mailed/sent to the responsible party on 4/4/16 and 6/22/16. The notes did not indicate that Resident #2 was invited to the care plan meetings.

The care conference notes were reviewed. The notes dated 1/6/16, 4/6/16 and 7/5/16 did not indicate that the resident was invited or was involved in the care plan meetings.

On 7/26/16 at 3:51 PM, the Social Worker was interviewed. The social worker indicated that it was her responsibility to invite the responsible party (RP) to the care plan meetings. She normally sent out the care plan letters to the RP and document it in the social service notes and in the care conference notes. The social worker further stated that she was not aware until last month (June) that she has to invite the resident to the care plan meetings. The social worker stated

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F 280	Continued From page 16 that it was her fault for not inviting Resident #2 to the care plan meeting that was held on July 5, 2016. On 7/27/16 at 12:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that she expected alert and oriented residents to be invited to the care plan meetings.	F 280		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility to provide a splint as recommended by occupational therapy to prevent further decrease in range of motion for one of two residents reviewed for range of motion and contractures (Resident #39). The findings included: Resident #39 was admitted to the facility 4/16/15 and last readmitted to the facility on 5/7/16. Cumulative diagnoses included cerebrovascular accident (CVA) and hemiparesis (loss of use of one side of the body) affecting left non-dominant side. An Admission Minimum Data Set dated 5/14/16	F 318	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F318 Resident #39 did not experience any adverse effects or decline in function related to not implementing a care plan or not wearing a splint. Resident # 39 was referred to therapy and was evaluated on 8/8/16 for contracture and splint	8/19/16

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F 318	Continued From page 17 indicated Resident #39 was cognitively intact. Limitation in range of motion was noted for one side of her upper and lower extremities. An Occupational Therapy discharge summary dated 6/2/16 indicated occupational therapy was discontinued on 5/27/16 and stated Resident #39 tolerated wearing a left hand splint 4-6 hours per day and care giver education was completed for the wearing and care of splint. A FMP (functional maintenance plan) was established for splinting, positioning and exercise. Discharge disposition indicated "nursing--restorative nursing". A care plan dated 7/27/15 and last edited on 5/27/16 stated Resident #39 was at risk for poor hygiene related to impaired mobility. Interventions included, in part, to follow physical therapy, occupational therapy and speech therapy recommendations. There was not a care plan for splint use. On 7/25/16 at 4:51PM, an observation of Resident #39 was conducted. Resident #39 was unable to move her left hand or open her fingers. She did not have a hand splint in place. On 7/26/16 at 4:55PM, an observation of Resident #39 revealed she did not have a hand splint in place. Resident #39 had her arm held across her abdomen. Her fingers were curled inward and she could not move her left hand. On 7/27/16 at 3:22PM, Resident was observed in her room. Her hand was held across her abdomen. Her fingers were curled inward and she did not have a splint in place. On 7/27/16 at 4:55PM, an interview was	F 318	management. Resident will be referred to restorative nursing program for splint management when therapy is completed. Residents with potential The following was accomplished: 1.All residents with splints have been reviewed for appropriate care plans and that the correct splints are in place and being worn properly by the MDS (Minimum Data Set) coordinator on 8-8-16-16. No additional issues identified. 2.All residents who were referred to restorative nursing program for splint management were reviewed for an order in the electronic health record, an appropriate care plan in place, for proper splint in place and that it is being worn properly. 3.100% of all residents will be evaluated utilizing the “contracture risk” observation in the electronic health record by licensed staff nurses to evaluate for contractures and possible need for splints. Residents will be referred to therapy for splint evaluation as indicated by the evaluation. Completion date8-19-16 4.An audit tool was developed to audit 100% of resident’s that had splints or referrals for splints. The audit includes: A.Residents that had splints and if the resident had an order for the splint in the electronic health record, a care plan implemented and that the splint was in place and being worn properly.	

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F 318	Continued From page 18 conducted with the restorative aide who stated she did not have Resident #39 in any restorative program for range of motion and/ or splints. On 7/28/2016 at 8:44AM, an interview was conducted with NA #1. She stated she was familiar with Resident #39 and worked with Resident #39 on day and evening shift. She stated she was able to bathe Resident #39's left hand but the resident could not open her fingers and she complained of pain and said it hurt her when staff tried to straighten her fingers and open her hand to wash her palm. NA #1 stated she had never seen a left hand splint for Resident #39 and she did not wear a splint for her left hand. An observation of Resident #39 on 07/28/2016 at 8:50AM was conducted. Resident #39 did not have a splint on her left hand. On 7/28/2016 at 8:59AM, an interview was conducted with the Occupational Therapist. She stated Resident #39 was not referred to restorative nursing. She stated the nursing assistants who cared for Resident #39 were in-serviced regarding the application and care of the left hand splint. The Occupational Therapist stated Resident #39 had a resting hand splint for her left hand when she was discharged from occupational therapy. On 7/28/2016 at 9:06AM, an interview was conducted with Nurse #1. She stated she did not know if Resident #39 had a splint for her left hand. She reviewed the medication Administration Record (MAR) and Treatment Administration Record (TAR) and did not see any orders/ reference to a left hand splint. Nurse #1 stated, normally, if nursing staff was to apply a	F 318	B.Residents who were referred by Occupational Therapy to restorative nursing program for splint management had an order in the electronic health record, had the proper splint, that it was being worn properly and the care plan was initiated. Measures put in place: 1.The therapy staff, MDS nurse #1 and MDS nurse #2, and nursing staff was educated on the proper referral process for the restorative program and the implementation of care plans by the Regional Therapy Manager and the Corporate RN. Education provided including but not limited to: proper fitting of splints, proper communication of need for splints by writing orders in E.H.R, proper education to nursing staff concerning application of splints and proper process of completing the referral for the restorative program by 8-17-16. 2.The newly developed audit tool will be used to complete audits on care plans and referrals made to restorative program to verify that care plans/referral process is being properly implemented. Monitoring: 100 % of all residents wearing splints and residents referred from occupational therapy to restorative nursing program for splint management will be audited weekly for 8 weeks, then monthly for 3 months by	

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F 318	Continued From page 19 splint, the therapist would inform the licensed staff and train them on the application of the splint. There would be a physician's order on the medical record and it would be recorded on the MAR and/ or TAR. Nurse #1 checked Resident #39's room and there was not a hand splint in her room. On 07/28/2016 at 9:21AM, an interview was conducted with the Director of Nursing. She stated when Resident #39 completed occupational therapy and was issued a left hand splint, therapy should have communicated with administrative nursing during the morning meeting the need for the splint and therapy should have trained the restorative aide regarding the application of the left hand splint. She stated, to her knowledge, all splints were applied by restorative nursing. She stated she expected a physician's order to be written for the splint and orders to check under the splint for skin integrity. The application of the splint and skin observation should be documented on the MAR. On 7/28/16 at 9:20AM, an interview was conducted with the Occupational Therapist. She reviewed the discharge summary for Resident #39 and, when asked regarding the discharge disposition of "nursing-restorative nursing" , she stated that usually indicated that Resident #39 was to be referred to restorative nursing. She stated that the Occupational Therapy Assistant was the one who worked with resident #39 and she did not think Resident #39 was referred to restorative nursing. On 7/28/16 at 9:25AM, an interview was conducted with the occupational therapy assistant. He reviewed the discharge summary	F 318	MDS nurse #1 and MDS nurse #2. Audits will continue quarterly and the results will determine the need for more frequent monitoring. QA: All audit information will be brought to the QA committee by the MDS coordinator and analyzed and reviewed by the DON at the QA committee meeting.	

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F 318	Continued From page 20 and saw the disposition "nursing-restorative nursing" . He stated he did not know about that and he just worked with the resident. On 7/28/2016 at 9:42AM, an interview was conducted with MDS Nurse #2 who was responsible for the restorative nursing program. She stated she had not received a referral sheet from occupational therapy for Resident #39. MDS Nurse #2 stated all residents who had splints were in the restorative nursing program for splint application and care. She said the restorative aides were the ones who had more training for splint application.	F 318		
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 record review, observation and staff interview, the facility failed to label and date nutritional supplements when pulled from the freezer in 1 of 1 stand up refrigerator in the kitchen. Findings included: The manufacturer instruction of magic cup (nutritional supplement) indicated that the shelf	F 371	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care.	7/29/16

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F 371	Continued From page 21 life (refrigerated) was up to 5 days. The manufacturer instruction for mighty shakes (nutritional supplement) indicated that the shelf life (refrigerated) was up to 14 days. On 7/25/16 at 10:10 AM, initial tour of the kitchen was conducted with the Certified Dietary Manager (CDM). There were 7 thawed magic cup and 9 thawed vanilla shakes observed inside the standup refrigerator that were undated. On 7/25/16 at 10:13 AM, the CDM was interviewed. The CDM stated that she did not have to date the magic cup and the shakes when stored in the kitchen refrigerator but once they were brought out on the hall they should be dated and they were good for 2 days. On 7/27/16 at 2:30 PM, the Regional Dietary Manager was interviewed. The dietary manager indicated that the shakes and the magic cup should be dated and labeled with a pull and use by date once pulled from the freezer and removed from the manufacturer package. He added that shakes were good for 14 days and magic cups were good for 3 days once pulled from the freezer.	F 371	F371 No residents were noted to be affected by the omission of a label/date on the supplements. Residents with potential The following was accomplished: 1.The Dietary Manager labeled all defrosted magic cups and shakes with the date pulled and use by date on 7-27-16 2.The Dietary Manager in serviced all dietary staff on the new labeling procedures on 7-27-16 Measures put in place: 1.The Dietary Manager or Assistant Dietary manager will observe all supplements daily to ensure that new labels/dates are placed on all defrosted magic cups and shakes. 2.An audit tool was developed to monitor supplements for labels/dates. The audit tool included, the date of the audit, the location (walk in cooler, walk in freezer, refrigerator and the dry storage) and whether all supplements were labeled/dated. Monitoring: 1.The Dietary Manager or Assistant Dietary Manager will audit the walk in cooler, walk in freezer, refrigerator and the dry storage to ensure that all items are	

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F 371	Continued From page 22	F 371	labeled correctly with dates, daily for 1 month and weekly for 3 months and monthly for 3 months. The results of the audits will determine the need for more frequent monitoring. QA: All audit information will be brought to the monthly QA meeting monthly by the Dietary Manager to be analyzed and reviewed by the by the QA committee.	
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.	F 373		8/17/16

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F 373	Continued From page 23 The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility allowed residents to be fed by employees who had completed a Feeding Assistance course that was not state approved	F 373	Filing of this plan of correction Does not constitute admission that The deficiencies alleged did in fact Exist. The plan of correction is filed in	

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F 373	Continued From page 24 for 2 (Resident # 2 & #58) of 2 residents observed being fed by non-nursing staff in the main dining room. Findings included: 1. Resident #2 was originally admitted to the facility on 12/26/13 with multiple diagnoses including dysphagia. The annual Minimum Data Set (MDS) assessment dated 7/12/16 indicated that Resident #2 needed extensive assistance with eating and had no sign/symptoms of possible swallowing disorder. On 7/25/16 at 10:10 AM, an entrance conference was conducted with the administrator and the Director of Nursing. During the entrance conference and review of the information provided by the facility revealed that the facility had no paid feeding assistants. On 7/25/16 at 12:10 PM, a dining observation was conducted in the main dining room. Resident #2 was observed sitting at a table with a pureed diet and a thin liquid in front of her. The certified dietary manager (CDM) was observed to sit beside Resident #2 and started feeding the resident. Resident #2 was observed coughing during the meal. On 7/27/16 at 8:41 AM, the CDM was interviewed. She stated that she had watched a video last year (unable to remember exact date) and had read handouts on feeding, setting up residents for feeding, use of protector and positioning. The handouts were given by the staff development coordinator who was no longer employed at the facility. She indicated that she didn't receive training on infection control, feeding techniques, appropriate response to resident	F 373	Evidence of the facilities desire to comply With the requirements and to continue to Provide high quality care. F373 Residents # 2 and #58 did not experience any adverse effects from being assisted with feeding by staff members. Residents with potential The following was accomplished: 1.All staff will be in serviced by the Administrator or SDC(Staff Development Coordinator) that Peak Resources Pinelake will not have untrained employees feeding residents by 8/17/16 2.Those employees, who are licensed or certified, will perform the duty of feeding residents Measures put in place: 1.Administrator and weekend RN supervisor will observe the dining hall, the restorative dining room and random rooms on the hallways for breakfast, lunch and dinner during the weekday and weekend to ensure that only those employees that are licensed or certified are assisting residents with feeding. 2.An audit tool will be utilized to ensure the policy is being followed. This audit tool will include the date, location and whether those employees licensed and/or certified are assisting residents with feeding.	

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F 373	Continued From page 25 behavior, communication and interpersonal skills or safety/emergency procedure. She added that she had fed residents in the dining room in the past but not on a regular basis. She also stated that she was not informed what resident to feed and not to feed. On 7/27/16 at 12:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that the 2 employees who were observed feeding residents were not trained on a state approved training course and should not be feeding residents. 2. Resident #58 was admitted to the facility on 5/11/14 with multiple diagnoses including Huntington disease with dysphagia. The quarterly Minimum Data Set (MDS) assessment dated 6/15/16 indicated that Resident #58 needed extensive assistance with eating and showed sign/symptoms of possible swallowing disorder (loss of liquids/solids from mouth when eating/drinking). On 7/25/16 at 10:10 AM, an entrance conference was conducted with the administrator and the Director of Nursing. During the entrance conference and review of the information provided by the facility revealed that the facility had no paid feeding assistance. On 7/25/16 at 12:10 PM, a dining observation was conducted in the main dining room. Resident #58 was observed sitting at a table with a pureed diet and a thin liquid in front of him. The administrator was observed to sit beside Resident	F 373	Monitoring: 1.The Administrator and weekend RN supervisor will audit dining halls, the restorative dining rooms and random halls during the weekday and weekend to ensure that residents needing assistance eating are being provided that service by only licensed staff and CNA's, daily for 1 month and weekly for 2 months and monthly for 3 months. The results of the audits will determine the need for more frequent monitoring. QA: All audit information will be brought to the monthly QA meeting monthly by the Administrator to be analyzed and reviewed by the QA committee.	

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F 373	Continued From page 26 #58 and started feeding the resident. Resident #58 was not observed coughing during the meal. On 7/27/16 at 11:05 AM, the administrator was interviewed. The administrator stated that he had watched a video on feeding in April 2016 but he didn't think it was a state approved training. The administrator added that Resident #58 was supposed to be in restorative dining but the restorative aides were not available so he fed him. He stated that it would not happen again. On 7/27/16 at 12:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that the 2 employees who were observed feeding residents were not trained on a state approved training course and should not be feeding residents.	F 373		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation	F 425		8/17/16

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F 425	Continued From page 27 on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, observation and facility and pharmacy staff interview, the facility failed to obtain and provide the routine medications prescribed for 3 (Resident # 21, #2 & # 120) of 8 sampled residents reviewed for medications. Findings included: The facility's policy on ordering and receiving medications from (name of pharmacy) dated 3/1/2011 was reviewed. The policy read in part " Medications and related products are received from (name of pharmacy) on a timely basis. Repeat medications (refills) are ordered by either peeling the reorder barcode tab from the label and placing it on the pharmacy reorder form or submitting the refill request electronically using the facilities EHR (electronic health records) system and ordered as follows: reorder medications ordered when needed for the resident with as much advance notice of need to assure an adequate supply is on hand, the refill order is called in, faxed or otherwise transmitted to the pharmacy, refill medication orders must be faxed to the pharmacy by 1:30 PM in order to be filled the same business day, otherwise, the refill order will be filled the next business day. If a refill order is needed after 1:30 PM for the same business day, nurse must call the pharmacy. " 1. Resident #21 was originally admitted to the facility on 2/14/07 with multiple diagnoses	F 425	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact Exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F425 Residents #21, #2 and #120 did not experience any adverse effects related to medications not being available. Resident #21 medication was obtained on 7-20-16, Resident #2 medications were obtained on 5-1-16 and Resident #120 medication was obtained on 7-27-16. Residents with potential The following was accomplished: 1.The pharmacy updated the policy on ordering medications and the procedure for obtaining medications when they are not available in the medication cart which states (If medication is unavailable in the emergency kit, facility should request for Medipack Pharmacy to call the medication into the back up pharmacy or special deliver to facility from Medipack Pharmacy. on 7/20/16.	

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F 425	Continued From page 28 including Hypertension. The July 2016 physician's orders for Resident #21 were reviewed. The orders included Lisinopril (antihypertensive drug) 2.5 milligrams (mgs) by mouth at bedtime for Hypertension, started on 2/27/16. The July 2016 Medication Administration Records (MARS) for Resident #21 were reviewed. The MARs revealed that the resident did not receive Lisinopril on 7/16, 7/17, 7/18 and 7/19 due to the reason of " medication (Lisinopril) not available " . The weekly blood pressure readings were reviewed for Resident #21. The blood pressure on 7/7/16 was 135/76, on 7/14/16 was 135/78 and on 7/21/16 was 151/75. On 6/27/16 at 12:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that the nurses re-ordered medications when running low (5-7 doses left). Medications ordered before 5 PM were delivered around 10:30 -11 PM same day and if after 5 PM, the medications were delivered on the next day delivery. If a medication was not delivered, the nurse should call the pharmacy and the pharmacy would call the backup pharmacy and the facility would pick up the medication from the back up pharmacy. The DON further indicated that sometime in June 2016, she realized that there were issues of not having the medications available. Every morning she had to check with the nurses if any medications did not come in and she had to call the pharmacy on several occasions. She also had initiated an audit of the medication carts on a weekly basis and still finding issues of not having medications available. The DON added that not having the medication delivered on time was the fault of both the pharmacy and nursing but she	F 425	2.All full time, part time and as needed licensed staff, Medication Aide and Medication Tech, will be in serviced by the SDC (Staff Development Coordinator) on new pharmacy protocols by 8-17-16. If a full time, part time or as needed licensed staff, Medication Aide or Medication Tech is unable to attend these in-services they will be removed from the schedule until they attend the in-service. All new licensed staff, Medication Aides and Medications Tech hired will be in serviced during orientation by the SDC on new pharmacy protocols. 3.All carts were audited against EMAR, to ensure that all medications were in cart on 8-1-16. Any medications that were not available were obtained from the pharmacy. Measures put in place: 1.An audit tool was developed and will be used by two MDS (Minimum Data Set) #1 and MDS#2 nurses, Treatment nurse and Clinical Supervisor to audit medication carts and will be over seen by the Director of Nursing. The audit tool included, resident's name, medication not available and action taken to receive medication. 2.The Director of Nursing or Administrator will bring all medication over rides daily to morning meeting Monday thru Friday. Weekend medication over rides will be completed by the weekend supervisor.	

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F 425	Continued From page 29 didn't know the real cause of the issue. On 7/27/16 at 3:05 PM, Nurse # 4 was interviewed. Nurse #3 stated that she was assigned to Resident # 21 on 7/18/16 and her Lisinopril was not available. She had called the pharmacy and the pharmacy informed her that it was too early to refill the Lisinopril and they needed permission from the DON or administrator to be charged for the refill. The DON was aware of this issue and had given the nurses permission to tell the pharmacy that the DON had approved for the refill charges. Nurse #3 further indicated that most of the time the reasons given by the pharmacy for not sending the medication were too early for the refill, already sent to the facility or the pharmacy did not receive the reorder request. On 7/27/16 at 3:55 PM, the pharmacy technician was interviewed. The technician indicated that the pharmacy had received a reorder request for the Lisinopril on Resident #21 on 7/14/16. The 30 day supply of Lisinopril was sent to the facility on 6/25/16 and so it was too early to refill the Lisinopril. A form (refill too soon) was sent to the facility for them to fill out and sent back to the pharmacy allowing the pharmacy to bill the facility for the early refill. If the form was not sent back to the pharmacy or the facility had not called to give permission, the pharmacy would not send the medication to the facility. In this case the form was not sent back to the pharmacy or the facility had not called until 7/18/16. A nurse had called and gave approval for the charges. The Lisinopril was sent to the facility on 7/19/16 delivery. On 7/27/16 at 4:00 PM, the pharmacy manager	F 425	3.The medication compliance report will be run daily to ensure that all medications have been administered as ordered and any medications not available in the medication cart have been obtained. Monitoring: Medication cart audits will be performed by MDS#1, MDS#2 nurses, Treatment nurse and Clinical Supervisor Bi weekly for three months starting on 8-15-16, weekly for three months, monthly for three months and quarterly thereafter. The Director of Nursing will review the medication compliance reports daily, Monday through Friday and the nursing supervisor on the weekend will review the medication compliance reports on an ongoing basis. The results of the audits and compliance reports will determine the need for further monitoring. QA: All audit information will be brought to the QA meeting monthly by Director of Nursing to be analyzed and reviewed by the DON at the QA Committee meeting.	

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was interviewed. The manager also indicated that when a facility requested for a refill and it was too early, a form needed to be signed/initialed by the facility giving permission to charge the facility or the facility can call and give permission. If not, the pharmacy would not send the medication to the facility. He also stated that periodically, the reorder request from the facility was not received by the pharmacy and the IT department would take care of that issue. There were also instances that the medication was not received by the facility. The facility has to call the pharmacy within 1 day for the medication to be sent out.

2. Resident #2 was originally admitted to the facility on 12/26/13 with multiple diagnoses including dysphagia. The annual Minimum Data Set (MDS) assessment dated 7/12/16 indicated that Resident #2 ' s cognition was intact.

The July 2016 physician's orders for Resident #2 were reviewed. The orders included Phenobarbital 64.8 milligrams (mgs.) 2 tablets by mouth at bedtime for seizures, started on 2/27/16.

The April 2016 Medication Administration Records (MARs) for Resident #2 were reviewed. The MARs indicated that Resident #2 did not receive Phenobarbital on 4/26/16, 4/27/16 and 4/30/16 due to the " medication not available. "

The Phenobarbital level on 5/10/16 was within the normal limits.

On 6/27/16 at 12:55 PM, the Director of Nursing (DON) was interviewed. The DON stated that the

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nurses re-ordered medications when running low (5-7 doses left). Medications ordered before 5 PM were delivered around 10:30 -11 PM same day and if after 5 PM, the medications were delivered on the next day delivery. If a medication was not delivered, the nurse should call the pharmacy and the pharmacy would call the backup pharmacy and the facility would pick up the medication from the back up pharmacy. The DON further indicated that sometime in June 2016, she realized that there were issues of not having the medications available. Every morning she had to check with the nurses if any medications did not come in and she had to call the pharmacy on several occasions. She also had initiated an audit of the medication carts on a weekly basis and still finding issues of not having medications available. The DON added that not having the medication delivered on time was the fault of both the pharmacy and nursing but she didn't know the real cause of the issue.

On 7/27/16 at 3:05 PM, Nurse # 4 was interviewed. Nurse #3 was scheduled 3-11 shift as a unit manager and at times she worked on the floor. The nurse acknowledged that there was an issue of not having the medication available and the DON was aware of this issue. Nurse #3 further indicated that most of the time the reasons given by the pharmacy for not sending the medication were too early for the refill, already sent to the facility or the pharmacy did not receive the reorder request.

On 7/27/16 at 4:00 PM, the pharmacy manager was interviewed. The manager also indicated that when a facility requested for a refill and it was too early, a form needed to be signed/initialed by the

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facility giving permission to charge the facility or the facility can call and give permission. If not, the pharmacy would not send the medication to the facility. He also stated that periodically, the reorder request from the facility was not received by the pharmacy and the IT department would take care of that issue. There were also instances that the medication was not received by the facility. The facility has to call the pharmacy within 1 day for the medication to be sent out.

3. Resident #120 was admitted to the facility on 12/3/15. Cumulative diagnoses included cerebrovascular accident.

A review of physician ' s orders revealed an order for Eliquis (an anticoagulant medication used for the prevention of blood clots 5 milligrams by mouth twice daily.

A review of the medication Administration Record (MAR) for July 2016 revealed Eliquis 5 milligrams was to be administered daily at 8:00AM and 8:00PM. The MAR indicated the medication had not been administered on 7/26/16 at 8:00PM due to the " drug/ item not available pending delivery from the pharmacy " .

During a medication pass observation on 7/27/16 at 7:58AM, Nurse #2 indicated she did not have Eliquis available in the medication cart. She reviewed the electronic record for Resident #120 and stated it had been ordered form the pharmacy and it must not have " come in yet " . Nurse #2 stated she would notify the physician and obtain an order to hold the medication until it was received from the pharmacy. Nurse #2 documented on the MAR that Eliquis was not given pending pharmacy delivery.

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On 7/27/16 at 1:31PM, Nurse #2 stated the Eliquis for Resident #120 had been obtained from the back-up pharmacy and had been administered as ordered.

On 7/27/16 at 11:15AM, an interview was conducted with Nurse #3. She stated the medication card was flagged when there were 5-7 doses of a medication remaining and she would re-order it on the electronic MAR (E-MAR) at that time. She stated the medication usually would come in that night and be available the next day. Nurse #3 said there had been some problems with receiving medications after they had been reordered. She stated the facility also had a backup pharmacy where they could get medications.

On 7/27/16 at 12:30PM, an interview was conducted with the Director of Nursing. She stated she expected nursing staff to reorder the medication when there was 5-7 doses of medication left on the medication card. She stated nursing staff reordered the meds by clicking on the reorder button on the E-MAR and that would automatically send the message to the pharmacy. The medication would then come in that night if it was re-ordered prior to 5:00PM. If after 5:00PM, the medication would be delivered the next day. The main pharmacy was located in Winston-Salem. If the nurses did not receive the medication that night or the next day, they could check on the E-MAR and it would tell them when the medication was last re-ordered. If the medication was not delivered, the Director of Nursing stated that nursing staff should report it to her the next morning and she would call the pharmacy. If it was something that the doctor did

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not feel was imperative, the nurse would get a hold order until it was delivered. The Director of Nursing stated she began her employment in May and, during the past month, had realized that there were some issues with pharmacy delivery. She stated they did have a backup pharmacy. To use the backup pharmacy, the nurse would call the primary pharmacy and the primary pharmacy would call the backup pharmacy. The facility would then pick up the medication from the back up pharmacy.

On 7/27/2016 at 3:27PM, an interview was conducted with the pharmacy technician. She stated the procedure to have a medication refilled was as follows: A refill request was done electronically for Pine Lake. Getting the refill depended on when the refill order was received by the pharmacy and if the resident ' s insurance would pay for the medication. The pharmacy technician stated the " cut-off time " for medication refills was 1:30PM. After 1:30PM, the pharmacy would send the medication the same day if the facility called and told them they needed the medication that day.

On 7/27/16 at 3:40PM, an interview was conducted with the pharmacy manager. He stated he was not aware of any issues with refilling medications. He said the pharmacy sent the facility a sheet daily that indicated any medication that was too soon to be refilled and the facility had the opportunity to initial the sheet and fax it back or call the pharmacy to authorize the pharmacy to charge the facility. The pharmacy manager stated the pharmacy would not call the facility back after they had sent them the daily sheet but would wait for the facility to contact them with some guidance on what the

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 07/28/2016

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 425	Continued From page 35 pharmacy should do regarding refilling the medication. He said it had happened periodically that the pharmacy did not get the reorder when the facility sent it electronically. The pharmacy manager also stated if the medication was not in the tote that was delivered nightly but was listed on the medication sheet located inside the tote, the facility should call the pharmacy the next day and the pharmacy would resend the medication.	F 425		