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 _____	05/17/2017

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 Minimum Data Set (MDS) 3.0 Focused Survey was conducted May 16 - 17, 2017. The facility was not in compliance with applicable requirements of 42 C.F.R. Part 483, Health Standard Requirements for Long Term Care Facilities.	F 000		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is	F 278		6/9/17

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

Electronically Signed | 05/26/2017

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F 278	Continued From page 1 subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) to reflect the active diagnoses for 2 of 12 residents (Resident #3 and #4), failed to accurately code the MDS to reflect a fall for 1 of 12 residents (Resident #5), and failed to accurately code the MDS to reflect how many days' antipsychotic medications were given for 1 of 12 residents (Resident #1) reviewed for accuracy of the MDS. Findings included: 1. A. Resident #3 was originally admitted to the facility on 3/15/17 with diagnoses that included Acute Respiratory Failure with Hypoxia, Hypertension, and Anemia. Review of resident #3's MDS dated 5/5/17, coded as 5 day PPS (Prospective Payment System), did not have Dementia marked as an active diagnosis. A review of the cumulative diagnoses list had a diagnosis of Dementia with behavioral disturbance diagnosed on 3/23/17. A Pharmacy progress note dated 3/20/17 had documentation of the resident having a diagnosis of Dementia with Behavioral Disturbance. During an interview with the MDS Coordinator, the Director of Nursing, the Administrator, and the Regional Care Manager on 5/17/17 from 11:45 am to 12:30 pm, the MDS Coordinator indicated the assessment was not accurate and that	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 Provide high quality care. F278 Residents # 3, 4, 5 and 1 did not Experience any adverse effect related to coding Inaccuracy. All of the residents noted in the Statement of deficiencies had the MDS (Minimum Data Set) Corrected by the MDS coordinator. Residents with potential. The following was accomplished: 1.The MDS (Minimum Data Set) for residents # 3, 4, 5 and 1 was corrected by the MDS coordinator and re-submitted on 5-18-17. 2.100% of April and May MDS assessments will be audited for accuracy by 6-9-17 by the MDS team (MDS Nurse #1 and MDS nurse #2). If any resident	

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F 278	Continued From page 2 Dementia should have been marked under the Active Diagnosis section of the MDS. B. Resident #4 was admitted to the facility on 3/8/17 with diagnoses that included Atrial Fibrillation, and a Urinary Tract Infection. Review of resident #4's MDS dated 3/15/17, coded as an admission assessment had documentation of resident having an indwelling catheter. There were no genitourinary diagnoses marked in the active diagnosis section of the assessment. Review of Resident #4's MDS dated 3/22/17, coded as a 14 day PPS assessment had documentation of resident having an indwelling catheter. There were no genitourinary diagnoses marked in the active diagnosis section of the assessment. Review of a physician order dated 3/12/17 read in part: Cath care every shift. Additionally, the diagnosis listed on the order was documented as Crossing Vessel and Stricture of Ureter without Hydronehrosis. A review of the cumulative diagnoses list had documentation of the resident having a diagnosis of Crossing Vessel and Stricture of Ureter without Hydronehrosis diagnosed on 3/12/17. During an interview with the MDS Coordinator, the Director of Nursing, the Administrator, and the Regional Care Manager on 5/17/17 from 11:45 am to 12:30 pm, the MDS Coordinator indicated the assessment was not accurate and that Crossing Vessel and Stricture of Ureter without Hydronehrosis should have been documented under the Active Diagnosis section of the MDS. 2. Resident #5 was admitted to the facility on	F 278	assessment is found to have an error in coding, that resident's assessments for January 2017, February 2017 and March 2017 will be audited by the MDS team to ensure accuracy. If any resident assessments' are inaccurate, a modification will be completed by the MDS team and resubmitted when error has been found. Measures put in place: •Both MDS coordinators (MDS nurse #1 and MDS nurse #2) were educated regarding the assessment process and coding the MDS accurately by the Director of nurses or the Regional Care Manager on 5-22-17. •The MDS team will be using a pre-assessment tool which includes the following information: Diagnosis, orders, Doctor visits, events for example, falls, skin tears and bruises, progress notes, scanned documents, electronic medical and treatment record, activities of daily living documentation, range of motion, continence record, all items listed on section O, wounds and Pain. This pre-assessment sheet will compare with information keyed on the MDS assessment to ensure accuracy.This tool will be used on a 100% of MDS assessments. Monitoring: •Starting on 5-22-17 each MDS coordinator will audit 25% of the other MDS coordinators assessments weekly	

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F 278	Continued From page 3 1/31/17 with diagnoses that included Atherosclerotic Heart Disease and Diabetes Mellitus. Review of Resident #5's MDS dated 5/3/17, coded as a quarterly assessment, had documentation that the resident had not experienced any falls since the prior assessment. Review of the facility incident log for March 2017 revealed the resident had a fall on 3/12/17. Review of the resident's medical record revealed a note titled "Event Details", dated 3/12/17. The note had documentation that the resident was guided to the floor by a nursing assistant. During an interview with the MDS Coordinator, the Director of Nursing, the Administrator, and the Regional Care Manager on 5/17/17 from 11:45am to 12:30pm, the DON (Director of Nursing) indicated that the resident had a fall on 3/12/17. The MDS Coordinator indicated the assessment was inaccurate and that the fall should have been coded on the MDS. 3. Resident #1 was admitted to the facility on 1/6/17 with diagnoses that included Schizoaffective disorder and Type 2 Diabetes Mellitus. Review of Resident #1's MDS dated 4/15/17 coded as a discharge-return anticipated assessment, had documentation of resident receiving antipsychotic medication for 7 of 7 days of the look back period (April 9-15, 2017).	F 278	for 3 months, then monthly for 9 months using the Resident assessment accuracy audit tool. The resident assessment accuracy audit tool will ensure that Diagnosis are coded correctly, falls are coded correctly, medications are coded correctly and that the total MDS assessment has no errors. •The Regional Care Manager will audit 10% of resident assessments monthly for 4 months for accuracy, utilizing the resident assessment accuracy audit tool. •The results of any audits will determine the need for further monitoring. QA: All audit information will be brought to monthly QA meeting to be analyzed and reviewed by the DON and the QAPI Committee members.	

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F 278	Continued From page 4 Review of a Physician Order dated 3/3/17 revealed Olanzapine 30mg to be given by mouth at bedtime. Review of the April 2017 MAR (Medication Administration Record) had documentation that the resident received the Olanzapine 6 of the 7 days of the look back period (April 9, 10, 11, 12, 13, and 14, 2017). During an interview with the MDS Coordinator, the Director of Nursing, the Administrator, and the Regional Care Manager on 5/17/17 from 11:45am to 12:30pm, the MDS Coordinator indicated the assessment was inaccurate and that it should have been coded as receiving antipsychotic medication for 6 of 7 days of the look back period.	F 278		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance	F 520		5/30/17

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F 520	Continued From page 5 committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put into effect September 2016. This was for a recited deficiency (F278) which was originally cited in July 2016 during a recertification survey and was recited again during a Minimum Data Set (MDS) 3.0 Focused Survey of May 16 and 17, 2017. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program.	F 520	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. F520 Corrective actions as described in the Plan of Correction were taken for Resident's # 3, 4, 5, and 1 relative to inaccurate coding on the MDS (Minimum Data Set).	

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F 520	Continued From page 6 The Findings Included: This tag is cross referred to: F 278: Accuracy of Assessment. Based on record review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) to reflect the active diagnoses for 2 of 12 residents (Resident #3 and #4), failed to accurately code the MDS to reflect a fall for 1 of 12 residents (Resident #5), and failed to accurately code the MDS to reflect how many days' antipsychotic medications were given for 1 of 12 residents (Resident #1) reviewed for accuracy of the MDS During the previous recertification survey of 7/28/2016, the facility was cited a deficiency at F278 for failure to accurately code the Minimum Data Set (MDS) assessment in the areas of dialysis (Resident #154), cognition (Resident #39) and psychotropic medications (Resident #89, #99) for four of twenty sampled residents. An interview with the Administrator, who is responsible for the Quality Assessment and Assurance Program was conducted on 5/17/2017 at 12:45pm. During this interview, the Administrator stated the MDS assessments monitoring for accuracy was ongoing and that they had increased the frequency for monitoring the MDS assessments for accuracy in April 2017.	F 520	Residents with Potential: •Facility QAPI committee members were in-serviced by the Administrator and the Director of Nursing about the Quality Assurance Performance Improvement Committee, program and procedures by 5-30-17. The in-service objective is: •Identify and review issues from past surveys and evaluate the current plan for its effectiveness and change the plan, as necessary. •The Facility committee members will understand the purpose of the QA program i.e.: to provide a means for a resident(s) care and safety issues to be resolved. •Committee members will understand how the QAPI Committee monitors issues and follows up with unresolved issues that have been identified. Systemic changes: •The QAPI policy was reviewed by the Administrator on 5-22-17, the policy states the facility shall develop, implement and maintain an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care and to resolve identified problems. No changes to the policy were necessary. •A tool was developed, titled Self	

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F 520	Continued From page 7	F 520	Evaluation. The tool included the following: o Does the QAPI committee have a current plan in place? o Does the committee identify who is responsible to oversee the plan/project? o Is the plan working? o If the plan is not working have changes been put in place to improve? o Is the outcome measurable? o Has the project been successful? o Can the plan be considered resolved? •This tool was developed for a QAPI sub-committee to establish the successfulness of the QAPI projects and make recommendations as necessary. Monitoring: •The Self-Evaluation tool will be completed by the sub-committee at scheduled meetings once a month prior to the next scheduled QAPI monthly meeting. •The sub-committee is made up of 4 members of the QAPI general Committee. •Findings of the sub-committee will be addressed at the monthly QAPI meeting when all participants attend. •The Self-Evaluation tool will be utilized for 6 months; ongoing use of the tool will be determined by the prior 6 months of self-Evaluating the QAPI process. QAPI	

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F 520	Continued From page 8	F 520	The results of the self-evaluation tool will be reviewed at the monthly QAPI meeting and changes or recommendations will be discussed as necessary.	