STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345395	A. BUILDING _____ B. WING _____	C 07/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES-CHERRYVILLE	7615 DALLAS CHERRYVILLE HIGHWAY CHERRYVILLE, NC 28021

(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 273 SS=E	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT (b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete admission comprehensive assessments within the required 14 day time frame for 3 of 3 sampled residents reviewed for completion of the Minimum Data Sets and Care Area Assessments (Residents #191, #221, and #222). The findings included: 1. Resident #221 was admitted to the facility on 06/30/17. Her diagnoses included cerebral infarct, viral conjunctivitis, dysphagia and chronic pain. The admission Minimum Data Set (MDS) had an assessment reference date of 07/14/17. The MDS was noted to be "in process" per the computer program which contained the MDS. Reviewing the MDS revealed section G which	F 273	Filing the plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. F273 For Residents # 191, #221, and #222, the comprehensive assessments including the Care Area Assessments (CAAs) were completed by the MDS Coordinator on 7/18/17, 7/20/17, and 7/18/17 respectively. For all residents, an audit tool was developed to include if the comprehensive assessment, the CAAs, and the corresponding care plans were completed within 14 days of admission. The audit	7/31/17

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

Electronically Signed | 07/31/2017

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F 273	Continued From page 1 coded her abilities for activities of daily living skills, section H which coded bowel and bladder information, section M which coded skin conditions and section N which coded medications were not completed. In addition the Care Area Assessments for the triggered areas were not completed. As of 07/18/17 at 10:02 AM, the RN had not signed the MDS verifying its completion. Interview with the MDS coordinator on 07/17/17 at 2:38 PM revealed she had worked as MDS coordinator a little over a year. She stated she had been doing MDS's alone since April until 2 weeks ago when a new staff person began training as a MDS nurse. She stated that she has had no hands on assistance to complete the MDS's within the time frame by corporate. She confirmed that Resident #221's MDS and CAAs were not completed within the required timeframe. Interview with the Administrator on 07/18/17 at 11:11 AM revealed that she was aware that MDSs and CAAs were completed late. She stated this was a recent problem as a new staff hired to assist did not work out and they were in the process of training a new MDS nurse to assist the MDS Coordinator. She further stated there have been people coming in on the weekend to try to keep up with the completion of the assessments. 2. Resident #222 was admitted to the facility on 06/30/17. His diagnoses included myocardial infarction, urinary tract infection, chronic pain, dysphagia, hypertension and major depressive disorder.	F 273	will be completed by the Director of Nursing for 100% of all new admissions since July 1, 2017. Incomplete assessments and CAAs will be completed as necessary by the MDS Coordinators. Education will be provided to the MDS Coordinators by the Administrator regarding the importance of completing the comprehensive assessments including the Minimum Data Set (MDS) and CAAs within 14 days of admission to the facility. The MDS Timeliness Audit Tool that was developed will be completed by the Director of Nursing weekly for all new admissions for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting.	

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The admission Minimum Data Set (MDS) had an assessment reference date of 07/14/17. The MDS was noted to be "in process" per the computer program which contained the MDS. The MDS appeared to be completed but review of the Care Area Assessments (CAAs) revealed the activities of daily living skills which was a triggered area was dated 07/13/17 but did not contain an analysis of findings.

As of 07/18/17 at 10:00 AM, the RN had not signed the MDS verifying its completion.

Interview with the MDS coordinator on 07/17/17 at 2:38 PM revealed she had worked as MDS coordinator a little over a year. She stated she had been doing MDS's alone since April until 2 weeks ago when a new staff person began training as a MDS nurse. She stated that she has had no hands on assistance to complete the MDS's within the time frame by corporate. She confirmed that Resident #222's activities of daily living skills CAA was not completed within the required timeframe. She further stated the staff person currently being trained was responsible for this CAA. The new MDS staff nurse was also working on the floor as a nurse.

Interview with the Administrator on 07/18/17 at 11:11 AM revealed that she was aware that MDSs and CAAs were completed late. She stated this was a recent problem as a new staff hired to assist did not work out and they were in the process of training a new MDS nurse to assist the MDS Coordinator. She further stated there have been people coming in on the weekend to try to keep up with the completion of the assessments.

3. Resident #191 was admitted to the facility on

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06/29/17. Her diagnoses included systemic inflammatory response syndrome, migraines, hypertension, chronic pulmonary edema, chronic pain, sepsis, anxiety disorder and diabetes.

The admission Minimum Data Set (MDS) had an assessment reference date of 07/13/17. The MDS was noted to be "in process" per the computer program which contained the MDS. Section J which coded fall history and section L which coded dental concerns were not completed. In addition there were no Care Area Assessments (CAAs) completed for any triggered area as of 07/18/17 at 8:49 AM.

As of 07/18/17 at 10:04 AM, the RN had not signed the MDS verifying its completion.

Interview with the MDS coordinator on 07/17/17 at 2:38 PM revealed she had worked as MDS coordinator a little over a year. She stated she had been doing MDS's alone since April until 2 weeks ago when a new staff person began training as a MDS nurse. She stated that she has had no hands on assistance to complete the MDS's within the time frame by corporate. She confirmed that Resident #191's MDS and CAAs had not been completed within the required timeframe.

Interview with the Administrator on 07/18/17 at 11:11 AM revealed that she was aware that MDSs and CAAs were completed late. She stated this was a recent problem as a new staff hired to assist did not work out and they were in the process of training a new MDS nurse to assist the MDS Coordinator. She further stated there have been people coming in on the weekend to try to keep up with the completion of the assessments.

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F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff interviews, and family interview, the facility failed to consistently implement the planned intervention for 1 of 3 sampled residents reviewed for falls. Resident #211's tab alarm was not connected to her in order to alert staff when she was attempting to self transfer. The findings included:	F 323	F323 For Resident #211, the tab alarm was connected to the resident in order to alert staff when she was attempting to transfer on 7/18/17. For all residents, an audit was completed by the Nurse Supervisor/ Staff Development Coordinator (SDC) for all residents with alarms to verify that the alarms are in place as necessary. The	7/31/17

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F 323	Continued From page 5 Resident #211 was admitted to the facility on 06/15/17. Her diagnoses included a displaced fractured left femur, abnormalities of gait and mobility, anxiety disorder, hypertension and Alzheimer's disease. Review of a summary of investigation noted Resident #211 fell on 06/17/17 at 11:25 PM. The summary noted she attempted self transfer without assistance and before the nurse could stop her she stood up and fell to the floor. No injuries were noted except Resident #211 complained of hip pain and left side pain. The intervention included fall mats. Review of nursing notes and the investigation report revealed on 06/19/17 at 7:26 PM, Resident #211 was found on the floor at the bedside of her roommate, lying on her left side. The wheelchair position was consistent with the resident attempting to stand unassisted. The note stated Resident #211 was alert but unable to supply details of the fall but stated she needed to use the bathroom. She sustained a small abrasion on her left elbow. The nursing note further stated she was subsequently taken to the bathroom and used the commode and the nurse aide stated the resident had voided in the trash can earlier as well. The investigation report for the fall of 06/19/17 checked that she needed to be toileted frequently and had poor safety awareness. The admission Minimum Data Set (MDS) dated 06/22/17 coded her as usually being understood, sometimes understanding, having severely impaired cognitive skills, inattention, disorganized thinking and being nonambulatory. The MDS coded her as requiring extensive assistance of 2 staff for bed mobility, transfers, dressing, toileting	F 323	Intervention audit tool includes observing that the appropriate intervention/ alarm is in place and is functioning. All interventions were in place. Education will be provided to all staff by the SDC/ RN regarding the communication of interventions for incidents and the importance of appropriate interventions being in place for each resident to minimize the risk of injury related to incidents. The utilization of an alarm is listed on the individual resident's profile. The Intervention audit tool will be completed by the Nursing Supervisor/ SDC weekly for all residents utilizing an alarm for 8 weeks, then monthly for 4 months. The need for further audits will be determined based on the results of the audits for the prior 6 months. Results of the audits will be reviewed and analyzed by the Director of Nursing at the monthly QAPI meeting.	

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and hygiene. She required staff assistance to stabilize during transitions. The MDS also coded her as having had a fall prior to admission, a fracture, and 2 falls since admission.

The Care Area Assessment for Falls dated 06/28/17 noted that Resident #211 had a fall with a fracture while in the assisted living section and was admitted to the skilled facility for short term rehabilitation. It was noted she had 2 falls since admission without injury and used a low bed with fall mats. She required extensive assist with 2 staff for toileting and transfers and staff encouraged frequent toileting especially after meals and at bed time. She continued to receive therapy services.

The current plan of care addressing falls was dated with a start date of 06/19/17 which had a goal to minimize injury related to incidents. Interventions included:
*on 06/19/17 the intervention to assess the need for fall intervention including low bed, bed/chair alarm, non-skid strips on floor, gripper socks, raised toilet seat, padded floor next to the bed, wedge in chair was added;
*on 06/19/17 the intervention for fall mats beside the bed was added;
*on 06/19/17 the intervention to provide proper, well-maintained footwear was added; and
*on 06/20/17 the intervention of encourage toileting after meals and at bedtime was added.

Nursing notes dated 07/03/17 at 12:25 PM revealed Resident #211 was sitting in her wheelchair in her room prior to being noted on the floor in the bathroom sitting on her buttocks. There was no concerns when range of motion was performed and no hip rotation was observed

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although she complained of hip pain.

The summary of investigation for the 07/03/17 fall included the intervention to observe her when she was not in bed.

Resident #211 was observed on 07/17/17 at 10:50 PM in bed with both upper turn bars in the upright position, wearing regular socks, floor mats on each side of the bed were in place and the wheelchair at her bedside contained a clip alarm on the back, although there was no alarm attached to the resident. She remained in bed with no alarm on 07/17/17 at 11:37 AM. Then on 07/17/17 at 1:22 PM she was observed in bed with the alarm box now on the turn rail but not clipped to the resident. On 07/17/17 at 1:24 PM the nurse entered and spoke at bedside to the resident who was calling out but the nurse did not attach the alarm. At 1:26 PM, the Administrator entered and spoke to the resident at her bedside and did not attach the alarm.

On 07/17/17 at 1:31 PM occupational therapy aide entered and assisted Resident #211 to sit up and put shoes on and transferred her to the wheelchair. The alarm never sounded as it was not attached to the resident. During an interview with the occupational therapy aide on 07/18/17 at 10:53 AM, she stated the tab alarm should move with the resident from the chair to the bed and vice versa. She did not recall the alarm being attached yesterday during the transfer and it did not sound when she transferred Resident #211.

Interview with the family on 07/17/17 at 1:31 PM revealed family visited frequently and about 50% of the time the alarm was not attached. Family stated he attached the alarm yesterday to

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Resident #211 before he left the facility.

Resident #211 was observed on 07/17/17 at 2:55 PM and she was in bed with the tab alarm attached to her. Nurse Aide #1 stated during interview on 07/17/17 at 2:56 PM that she laid her down this morning and attached the tab alarm to her. She further stated the resident went to therapy twice this morning after she had laid the resident down and perhaps the therapist who laid her down after therapy this morning did not attach the alarm.

On 07/17/17 at 2:59 PM an interview with the physical therapy aide revealed she took Resident #211 to physical therapy that morning and then placed her back in bed. She stated she noted the alarm on the wheelchair but stated she just didn't transfer it to the bed when she put her back to bed.

Nurse Aide #2 stated on 07/17/17 at 4:07 PM Resident #211 used the fall floor mats and tab alarm to help prevent falls.

Interview with the Director of Nursing on 07/18/17 at 11:36 AM revealed the tab alarm was initiated after her last fall on 07/03/17. She further stated the facility tried to limit the use of alarms but Resident #211 was confused enough to not remember to call for help and did not remember her lack of ambulation abilities.

Interview with the charge nurse on 07/18/17 at 12:02 PM revealed the tab alarm was initiated for Resident #211 after her last fall on 07/03/17.