STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345494	A. BUILDING _____ B. WING _____	12/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - GASTONIA	2780 X-RAY DRIVE GASTONIA, NC 28054

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		12/20/17

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

Electronically Signed | 12/21/2017

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F 656	Continued From page 1 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to develop a plan of care with measurable objectives and timetables to address a significant diagnosis for 1 of 15 residents. (Resident #8). Findings included: Resident #8 was admitted to the facility on 05/19/17. Diagnoses included, in part, seizures, anemia and congestive heart failure. The Minimum Data Set (MDS) quarterly assessment dated 11/13/17 revealed the resident was severely cognitively impaired. A record review of Resident #8's care plan revealed there was no plan of care in place for the diagnosis and treatment of seizures. An interview was conducted with the MDS/Care Plan Nurse on 12/07/17 at 4:30 pm. The MDS nurse stated the facility developed a care plan for every significant diagnosis. The MDS nurse confirmed there was no care plan in place for seizures for this resident and there should be one. The nurse explained when a resident was admitted, their care plans were initiated based on their diagnoses. The nurse further added the interventions should be listed with a time frame of anticipated resolution and measurable goals. The nurse explained if there were any changes in a resident such as an infection, fall, pressure ulcer or a new diagnosis, the care plan should be updated. The MDS nurse stated it was an over sight that a care plan was not implemented for	F 656	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. For Resident #8, a care plan to address seizure activity was put in place. A root cause analysis was performed to address the processes that lead to this deficiency. The seizure diagnosis was not captured from the record during the care planning process. No adverse outcomes related to care plan compliance. This was completed on 12/8/2017. For all residents with the potential to be affected, a 100% audit of all care plans of residents with a seizure diagnosis was performed to ensure accuracy of completion of care plan related to seizures problematic comorbidities. This was completed on 12/11/2017 by our MDS Coordinators. For the systemic change, MDS coordinators, Social Worker, Therapy Director, Activities Director, Certified Dietary Manager and Registered Dietician were educated by the DON/Administrator concerning accuracy of completion of care plans related to problematic comorbidities, this was completed on 12/11/2017. This education	

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F 656	Continued From page 2 the diagnosis and treatment of seizures for Resident #8. An interview with the Director of Nursing (DON) on 12/8/17 at 2:05 pm revealed her expectation was that the care plans should reflect the care that was being provided for the resident.	F 656	was approved by the Regional MDS consultant and consisted of but not limited to the following: function of care plan, individualizing care plans, care plans are a working tool and update the care plans as needed. An action plan has been implemented to include the following: all admissions will be reviewed by DON/MDS/designee and assessed for a need of a seizure care plan and all problematic comorbidities noted upon admission. Furthermore, new orders will be reviewed daily in clinical meeting by DON/MDS/designee and the care plan will be updated and/or implemented for all problematic comorbidities. In addition, care plans will be reviewed with each comprehensive and quarterly assessment and updated, as appropriate. An audit tool was developed which includes monitoring to make sure the comprehensive care plan is put in place to address resident's needs to attain or maintain the highest level of function. The audit tool consist of reviewing individualized plan of care upon admission for the need of a seizure care plan or any problematic comorbidity, reviewing all new orders daily to capture new problematic comorbidities and reviewing the care plan with each quarterly and comprehensive assessment to capture problematic comorbidities. The MDS Coordinator/Regional MDS consultant/designee will audit 10% of all resident comprehensive care plans weekly for 4 weeks, then 10% every other week for 4 weeks and then monthly for 2	

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F 656	Continued From page 3	F 656	months to ensure care plan accuracy. Audits will determine the need for more frequent monitoring. All audits will be reported to the Administrator/designee. All audit information will be analyzed and reviewed by the QAPI Committee for a minimum of 4 months.	