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	345337	A. BUILDING _____ B. WING _____	01/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - ALAMANCE, INC	215 COLLEGE STREET GRAHAM, NC 27253

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F 000	INITIAL COMMENTS The survey team entered the facility on 1/2/18 to conduct annual recertificvation survey and was unable to return to the facility on 1/5/18 due to adverse weather of snow and unsafe road conditions. The survey team returned to the facility on 1/8/18 and completed the survey on 1/9/18. Event ID W4WV11	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		2/6/18

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

Electronically Signed | 02/02/2018

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F 657	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews, the facility failed to revise care plans to include discontinuation of electronic monitoring devices and use of a mechanical lift for 2 of 27 sampled residents (Residents #33 and #253). Findings included: 1. Resident #33 was admitted 12/23/15 with diagnoses that included unspecified dementia with behavioral disturbance, acute embolism/thrombosis of left lower extremity, and difficulty walking. a. The care plan dated 12/09/17 identified Resident #33 as an elopement risk with a Problem Start Date of 03/02/16. One of the interventions entered was to "equip resident with a device that alarms when [she] wanders." The most recent Minimum Data Set (MDS) dated 12/14/17 recorded severe cognitive impairment with behavioral symptoms. She required extensive assistance or total dependence for activities of daily living (ADLs) except for independent eating. No wandering was noted on the MDS during the seven-day look back period and the resident was not coded for use of a wander/elopement alarm. No electronic monitoring device was visible on Resident #33 ' s wrists or ankles during observations made throughout the survey, including 01/03/18 at 10:42 a.m., 01/08/18 at 12:30 p.m., 01/08/18 at 1:20 p.m., and 01/09/18 at 9:30 a.m. In an interview on 01/09/18 at 9:45 a.m., Nurse	F 657	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law. F-657 1. Root cause analysis was performed by facility to determine the cause of the deficient practice. The facility failed to follow process for care plan revisions secondary to clinical and Interdisciplinary Team meeting inconsistencies. In addition, staff failed to properly notify appropriate staff of change in transfer technique for resident #33. Director of Nursing revised the care plans for resident # 253 to include discontinuation of electronic monitoring devices on 1/9/18 and resident #33 to include discontinuation of electronic monitoring device on 1/9/18 and use of mechanical lifts on 2/1/18. Resident #253 and resident #33 were not adversely affected by the deficient practice. 2. The Staff Development Coordinator to educate all CNAs to review the residents profile before providing care to ensure proper transfer technique is performed and if there is an ADL functional change or any other inaccuracy in the resident profile, the CNA will immediately inform	

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F 657	Continued From page 2 Aide #4 indicated that Resident #33 did not use a monitoring device. She denied any concern about the resident exiting the facility unattended. Although the resident ' s room was next to a facility exit door, Nurse Aide #4 had not seen her near the door in an attempt to leave when the door was opened. In an interview on 01/09/18 at 11:45 a.m., Nurse #8 confirmed that Resident #33 did not use an electronic monitoring device. She did not consider the resident at risk for elopement, stating that the resident was less mobile now than when first admitted. b. The care plan for Resident #33 included an entry for the use of a "mechanical lift (Hoyer) for safe transfers as needed." The Approach Start Date was 09/15/16. The wheelchair of Resident #33 did not have a mechanical lift sling present during observations made throughout the survey, including 01/03/18 at 10:42 a.m., 01/08/18 at 12:30 p.m., 01/08/18 at 1:20 p.m., and 01/09/18 at 9:30 a.m. When asked, the resident was not able to provide any information about the use of the lift. She indicated that she was able to stand. In an interview on 01/08/18 at 12:50 p.m., Nurse Aide #3 confirmed that Resident #33 was able to stand and pivot. She stated that she did not use the mechanical lift with the resident because she believed the resident could transfer safely with one staff member assisting. In an interview on 01/09/18 at 1:45 p.m., the Occupational Therapy (OT) Manager stated that Resident #33 was not currently on their caseload.	F 657	the responsible nurse of the change or inaccuracy. This education will be completed by 2/6/18. The nurse will make a referral to therapy, as appropriate. The care plan and resident profile will be revised with any changes or inaccuracies, if necessary, by the DON/designee immediately. In addition, the DON/designee will review all orders daily during clinical meeting and care plans and resident profiles will be revised at that time for any pertinent changes. IDT Clinical At Risk meetings will be held weekly and any identified changes will be addressed in the care plan and resident profile for accuracy. The MDS nurses were educated by the Regional Care Manager on care plan revision process. Care plan/resident profiles review and revisions will occur after each assessment, including both the comprehensive and quarterly review assessments to ensure accuracy. Education was completed on 1/31/18 3. The DON, SDC, and MDS nurses will Audit 100% of Care Plans and resident profiles for electronic monitoring devices, mechanical lifts and any other inaccuracies to ensure the care plan accurately reflects the residents status. This will be completed by 2/6/18. To ensure continued compliance, 10% of all resident care plans will be reviewed at the Clinical At Risk meeting by the IDT team weekly for four weeks and then bi-weekly for two months. The results of these audits will determine the need for further monitoring of the POC. The results will be	

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F 657	Continued From page 3	F 657		

The resident was last seen by OT in December of 2016 and by Physical Therapy in February of 2017. She proposed that the use of the mechanical lift must have been initiated by Nursing based on the resident ' s readmission to the facility when she was in decline. She indicated that revisions to the care plan based on improvements in resident condition, i.e., discontinuing the mechanical lift, didn ' t need the approval of someone from Rehabilitation when nursing services initiated the care plan entry.

In an interview on 01/09/18 at 10:00 a.m., the MDS Coordinator confirmed that wandering behaviors were not present for Resident #33 and there was no use of a monitoring device for wandering according to the latest MDS document. She stated she was not aware that the current care plan did not reflect the lowered elopement risk. She indicated she was not aware that nursing staff were not using a mechanical lift for Resident #33 and that the care plan needed an update for her improved ability to transfer. She indicated that she usually learned of needed revisions by attending the daily department meetings and daily stand-up clinical meeting on the units. Staff could also notify her directly of a change in the care plan. She further stated that any nurse can update care plans and point-of-care guides but only a registered nurse could initiate an issue.

In an interview on 01/09/18 at 4:30 p.m., the Director of Nursing (DON) acknowledged that the care plan was not updated to reflect the lowered elopement risk for Residents #33. She stated that an elopement screen conducted in early October showed that a monitoring alarm was not needed. She explained that nursing staff noted and reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting.

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F 657	Continued From page 4	F 657		

were not using the mechanical lift for Resident #33 due to her improved ability to transfer safely. The DON shared her expectation that nursing staff followed interventions outlined in resident care plans and that revisions were done in a timely manner to keep the plans current.

2. Resident #253 was admitted 02/20/13 with diagnoses that included sequelae following cerebrovascular accident, difficulty walking, secondary Parkinson ' s disease, and unspecified dementia with behavioral disturbance. Hospice care was initiated 01/02/17 for end-stage chronic obstructive pulmonary disease.

The quarterly MDS dated 10/05/17 recorded severe cognitive impairment. He required extensive assistance for ADLs with total dependence for bathing. No wandering was noted on the MDS during the seven-day look back period and the resident was not coded for use of a wander/elopement alarm.

The care plan dated 01/05/18 identified Resident #253 as an elopement risk with a Problem Start Date of 01/26/15. One of the interventions entered was to "equip resident with a device that alarms when [he] wanders." The nursing problem was last reviewed 01/03/18.
No electronic monitoring device was visible on Resident #253 ' s wrists or ankles during observations made throughout the survey, including 01/03/18 at 11:25 a.m., 01/08/18 at 10:34 a.m., and 01/08/18 at 12:44 p.m.

Resident #253 was not observed in his wheelchair stationary near any facility exit doors during the time of the survey. When asked, the resident was not able to provide information

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F 657	Continued From page 5	F 657		

about the use of any device that alerted staff if he left the facility.

In an interview on 01/08/18 at 12:20 p.m., Nurse Aide #3 indicated that the resident refused to wear a monitoring alarm and that the nurses were aware of this. She did not consider the resident an elopement risk because of his limited mobility and impaired cognition.

In an interview on 01/08/18 at 12:44 p.m., Nurse #8 indicated that the alarm was discontinued because the resident was not at risk for elopement.

In an interview on 01/09/18 at 10:00 a.m., the MDS Coordinator confirmed that wandering behaviors were not present for Resident #253 and there was no use of a monitoring device for wandering according to the latest MDS document. She stated she was not aware that the current care plan did not reflect the lowered elopement risk. She indicated that she usually learned of needed revisions by attending the daily department meetings and daily stand-up clinical meeting on the units. Staff could also notify her directly of a change in the care plan. She further stated that any nurse can update care plans and point-of-care guides but only a registered nurse could initiate an issue.

In an interview on 01/09/18 at 4:30 p.m., the DON acknowledged that the care plan was not updated to reflect the lowered elopement risk for Resident #253. She stated that an elopement screen conducted in early October showed that a monitoring alarm was not needed. The DON shared her expectation that nursing staff followed interventions outlined in resident care plans and

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F 657	Continued From page 6 that revisions were done in a timely manner to keep the plans current.	F 657		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to store 91 tablets and capsules in labeled packaging to identify the medication name, strength and expiration date in four of five medication carts inspected.	F 761	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet	2/6/18

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F 761	Continued From page 7 Findings included: 1. During an inspection of Station 3 ' s medication cart 3-A on 01/04/18 at 9:30 a.m., five loose white tablets and one loose colored tablet were found in the bottom of the second drawer on the right-hand side. In an interview on 01/04/18 at 9:30 a.m., Nurse # 1 could not identify the unpackaged medications and she wasted them. She acknowledged they were not labeled or stored correctly. 2. During an inspection of Station 4 ' s medication cart on 01/04/18 at 9:50 a.m., a total of 16 loose tablets were found in the bottom of two drawers. Two white tablets, one colored tablet and six partial tablets were loose in the second drawer on the right-hand side. Three white tablets, two colored tablets and two partial tablets were loose in the third drawer on the right-hand side. In an interview with Nurse #6 on 01/04/18 at 9:50 a.m., she indicated that had she seen the unpackaged pills she would have thrown them away in a secured container. Nurse #6 was observed discarding the medications after they were retrieved from the drawers. 3. During an inspection of Station 1 ' s medication cart 1-A on 01/04/18 at 10:05 a.m., a total of 64 loose pills and three capsules were found in the bottom of four drawers. Eighteen white tablets, 13 colored tablets, one capsule and seven partial tablets were loose in the second drawer on the right-hand side. Eight white tablets, seven colored tablets and two capsules were loose in the third drawer on the right-hand side. Three white tablets, three colored tablets and four	F 761	requirements established by state and federal law. F-761 1. Medication carts 3-A, 4, 1-A and 1-B were immediately cleaned out for all loose pills and unidentified meds. The medications were removed and destroyed per policy on 1/4/18. Root cause analysis was performed by the facility management staff to determine the cause of the deficient practice. The nurses were not cleaning their medication carts per facility practice. No residents were adversely affected by the deficient practice. 2. All licensed nursing staff were in-serviced by Staff Development Coordinator or her designee on proper cleaning of medication carts to include removal and destruction of any loose or unidentified medications located in medication carts. Education was completed on 1/9/18 3. An audit tool was developed to monitor all medication carts for any loose pills and unidentified medications. These audits will be conducted by the Staff development Coordinator, DON or her designee every shift for 1 week, daily for one month, and weekly for two months. The results of these audits will determine the need for further monitoring to ensure compliance with the POC. The results will be noted and reviewed in the monthly Quality Assurance and Performance	

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F 761	Continued From page 8 partial tablets were loose in the fourth drawer on the right-hand side. One loose white tablet was found in the first drawer on the left-hand side. In an interview with Nurse #5 on 01/04/18 at 10:05 a.m., she indicated that the loose medications must have been released from the blister packs when the drawer was packed full and the cards were pressed against each other. Nurse #5 was observed discarding the medications in a secured container. 4. In an inspection of Station 1 ' s medication cart 1-B on 01/04/18 at 10:35 a.m., one white tablet was found loose in the bottom of the fourth drawer on the right-hand side and one colored tablet was loose in the first drawer on the left-hand side. In an interview with Nurse #7 on 01/04/18 at 10:35 a.m., she identified the medications as not being labeled and discarded them in a secured container. In an interview on 01/08/18 at 4:00 p.m., the Director of Nursing acknowledged that the medications discovered on inspection of the medication carts were not stored correctly. She offered that the pills may have broken free from the pharmacy blister packs when they were moved against each another in the drawer, or that the pills had unintentionally fallen in the drawers when nurses popped them from the packs during administration. She shared her expectation that medications be stored in appropriately labeled containers or other packaging to include the medication name.	F 761	Improvement Committee meeting.	
F 812	Food Procurement,Store/Prepare/Serve-Sanitary	F 812		2/6/18

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F 812 SS=E	Continued From page 9 CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed label opened food in the walk in freezer, dietary staff failed use gloves during the dish washing process and also failed to maintain a clean ice scoop and ice scoop holder for the ice machine in the nourishment room. Facility also failed to prevent staff from bring personal food into the kitchen. Findings included: 1. Observation of the walk in freezer on 1/2/18 at 9: 15 AM revealed an opened, half-filled transparent bag containing food that looked like cut cauliflower not labeled and an opened bag containing three (3) frozen pieces of meat in a	F 812	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law. F-812 1. The food in the walk-in freezer that was unlabeled and undated was immediately discarded. The personal food and beverage was removed and placed into the employee break room. The ice	

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F 812	Continued From page 10 box labeled Beef Salisbury steak not labeled and dated. 2. Observation on 1/2/18 at 9:30 AM revealed staff entered into the kitchen with a brown bag with a restaurant label and 2 cold beverages in a clear plastic cup with straws. Staff was observed placing the brown bag and beverages on the clean steam table and sipping beverage from the one of the cups. Dietary Manager was made aware and he requested staff to remove the food and take it to their break room. During an interview with the Dietary Manager (DM) on 1/2/18 at 9:35 AM, DM indicated that any opened bag of food should be labeled and dated appropriately. He also stated that staff should not be bringing in their personal food to the kitchen as no eating or drinking was allowed inside the kitchen. He further stated that staff should put their personal food in the break room. During an interview with the dietary staff # 2 on 1/9/18 at 11:00 AM , dietary staff indicated that she had brought in food for another staff member and not noticed the surveyor and placed the food where it should not be placed. She stated that all personal food should be placed in the break room and not brought into the kitchen. 3. Observation of ice machine in the nourishment room near the nursing station 1 hallway on 1/8/18 at 12:32 PM revealed the ice scoop was placed inside the ice scoop holder that was not clean. The ice scoop holder had brown colored bottom that looked like dried dirt. Interview with DM on 1/8/18 at 12:35 PM revealed that the ice scoops and holder were washed by	F 812	scoops and holder were immediately cleaned. The employee that washed the dishes immediately discarded the white cloth, washed his hands and put on gloves. Root cause analysis was performed by the dietary manager. It was determined that dietary staff were not following facility policy. No residents were adversely affected by the deficient practice. 2. The Dietary Manager will educate all dietary staff on labeling and dating of food items. All dietary/kitchen staff will be responsible for the proper labeling and dating of food items stored in the kitchen. The dietary manager/designee will ensure proper labeling and dating of food items daily. The dietary manager will educate all dietary staff on proper cleaning of ice scoops and holders. The dietary manager/designee will inspect the ice scoops and holders in the nourishment rooms daily to ensure cleanliness during daily rounds. Education of all dietary staff to include removing of personal food and beverages in the kitchen area and proper hand hygiene while handling dishes. All education will be completed by 2/6/18. 3. An audit tool was developed to monitor proper labeling and dating of food items, cleanliness of ice scoops and holders, proper hand hygiene during the dish washing process, and no personal food and beverages in the kitchen area. These audits will be conducted by the Dietary Manager or his designee daily for 2 weeks, weekly for four weeks and then	

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dietary on a regular basis. He indicated he was not sure why it was not washed.

4. During dish washing observation on 1/8/18 at 2:09 PM, observed staff who was handling clean dishes not wearing gloves and using a white colored cloth that was placed near the clean stack of plates to wipe his hands frequently. The Dietary Manager made the observation too and asked the staff to remove the white colored cloth and wash his hands. The staff discarded the white colored cloth, but did not wash his hands and use gloves, and he returned to complete the task assigned.

During an interview with the dietary Staff #1 on 1/8/18 at 2:13 PM, staff indicated that he was using the white colored cloth to wipe his wet hands. The staff also indicated that he had forgotten to wash his hands and use gloves before returning to the task. The staff then went back and washed hands and wore gloves. Dishes were sent back through the dish washing cycle.

During an interview with the DM on 1/8/18 at 2:15 PM, DM indicated that dietary staff should not be using a napkin during dish washing and should be washing his hands and use gloves appropriately.

During an interview with DM on 1/9/18 at 1:00 PM, DM stated that it was his expectation that staff follow proper hand hygiene, appropriately label and date all food and use break room for their personal food. He further stated that all ice scoops and ice scoop holders should be washed and replaced daily in the nourishment rooms.

monthly for two months. The results of these audits will determine the need for further monitoring to ensure compliance with the POC. The results of the audit will be noted and reviewed in the monthly Quality Assurance and Performance Improvement Committee meeting.