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 02/24/2021

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 complaint investigation was conducted onsite on 2/23/21 and continued offsite on 2/24/21. One of four complaint allegations was substantiated resulting in a deficiency (F 686). Event ID # 6IVV11.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to assess and to obtain a treatment order when the pressure ulcer was first identified for 1 of 3 sampled residents reviewed for pressure ulcers (Resident #1). Findings included: Resident #1 was admitted to the facility on 2/28/17 with multiple diagnoses including Alzheimer's disease, diabetes mellitus and hypertension. The quarterly Minimum Data Set (MDS) assessment dated 9/5/20 indicated that	F 686	Filing the plan of correction does not constitute that the alleged deficiencies 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. Resident affected by the alleged deficient practice Resident #1 is no longer a resident at the facility.	3/8/21

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

Electronically Signed | 03/09/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 686	Continued From page 1 Resident #1 had severe cognitive impairment, needed extensive assistance with bed mobility and was at risk for pressure ulcer. The assessment further indicated that the resident had no pressure ulcer. The care area assessment (CAA) dated 3/5/20 for pressure ulcer revealed that Resident #1 was at risk for developing pressure ulcer due to impaired mobility and incontinence. Resident #1's care plan was reviewed. The care plan for pressure ulcer was initiated on 3/7/17 and was last reviewed on 9/5/20 had a problem of "at risk for pressure ulcer". The goal was "resident's skin will remain intact" and the approaches included "assist with turning and repositioning on care rounds, conduct a systemic skin inspection twice weekly with showers pay attention to the bony prominences, keep clean and dry, provide incontinence care after each incontinent episodes and report any signs of skin breakdown (sore, tender, red or broken areas)". Residents #1's weekly skin checks/observation forms were reviewed. The skin observation form dated 10/18/20 revealed that Resident #1 did not have a pressure ulcer. The skin observation form (completed by Nurse #1) dated 10/25/20 revealed that Resident #1 had an existing pressure ulcer to the sacrum. The form did not have the assessment of the pressure ulcer to include the stage, length, width, and depth. The form did not indicate the type of treatment to the pressure ulcer. The skin observation form (completed by Nurse #2) dated 10/28/20 revealed that Resident #1 had a stage 3 sacral pressure ulcer measuring 3.5 by 2.5 centimeter (cm.), 80% necrotic tissue and with scant serosanguinous exudate. The	F 686	Residents with the potential to be affected by the deficient practice On 2-24-21, all residents had a full skin audit completed by the Administrative Nursing Team, which included the Director of Nursing (DON), Registered Nurse Supervisor (RNS), Staff Development Coordinator (SDC), the Minimum Data Set nurses (MDS) #1 and #2 and the Treatment Nurse. No new skin impairments were identified. The Administrative Nursing Team also reviewed all residents with skin impairments to ensure that treatment orders were in place. This was completed on 2-25-21. All residents with skin impairments had treatment orders for the skin impairment. No other residents were affected by the alleged deficient practice. Systemic changes to prevent recurrence Wound care management protocols were reviewed by the Corporate Compliance Manager on 03/08/2021. No changes were required. All Licensed nursing staff were educated by the SDC on the following on 2/26/2021. New staff will be educated during orientation The following items must be completed by Licensed nursing staff when new skin impairments are observed. Notify the attending physician and report your observations of any new skin impairments.	

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F 686	Continued From page 2 form indicated that the doctor was notified, and a treatment order of calcium alginate covered with a foam dressing was obtained. Resident #1's physician's orders and Treatment Administration Records (TARs) for October 2020 were reviewed and there was no order or treatment documented to the sacral pressure ulcer prior to 10/28/20. Nurse #1 was interviewed on 2/23/21 at 1:53 PM. The nurse reported that she was assigned to Resident #1 on 10/25/20. During her weekly skin observation on 10/25/20, she found a foam dressing (no date/initial) on Resident #1's sacrum. When she removed the foam dressing, she noted an open area. Nurse #1 further stated that she applied a new foam dressing and notified Nurse #2 (Treatment Nurse). When asked how she notified Nurse #2 on 10/25/20 (Sunday), Nurse #1 replied that she didn't remember. Nurse #1 verified that she didn't assess the pressure ulcer and didn't obtain a treatment order assuming that the Treatment nurse was already aware of the pressure ulcer. She also stated that she didn't remember the appearance of the wound on 10/25/20 observation. Nurse #2 was interviewed on 2/24/21 at 9:24 AM. Nurse #2 stated that he started as Treatment Nurse in December 2019. He indicated that Nurse #1 had documented on the skin observation form dated 10/25/20 that Resident #1 had a sacral pressure ulcer. He revealed that he was not notified of this new open area on the resident's sacrum on 10/25/20. He added that somebody had identified the open area on the Resident #1's sacrum prior to 10/25/20 and covered it with a foam dressing without assessing	F 686	Obtain order for treatment immediately and implement physician orders. Notify the resident representative of the resident's condition. Implement additional nursing measures if appropriate i.e.: prevent further skin impairment. You must notify the treatment nurse, RN Supervisor and/or the Director of Nursing immediately following the discovery of a new skin impairment The following items must be documented when a new skin impairment is observed. The "Weekly Skin Observation" in the EHR will be completed by a nurse to document the weekly skin observations on each resident. If a new skin impairment is identified, a corresponding "Event" is created detailing assessment findings of the particular type of wound. A treatment must be initiated upon identification of any skin impairment. Treatment orders must include the wound location, type of wound, what cleanser and dressing is to be applied, and frequency of dressing change. All Certified Nursing Assistants (CNA's) were educated on assessment and documentation of skin integrity and how to correctly fill out a Stop & Watch form by the SDC. This was completed on 2-26-21. New staff will be educated during orientation CNA's will use Stop & Watch form to	

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F 686	Continued From page 3 the area or obtaining a treatment order. Nurse #2 reported that he was not made aware of the open area until 10/28/20. Nurse #1 was again interviewed on 2/24/21 at 10:14 AM. Nurse #1 verified that she was assigned to Resident #1 on 10/20/20, 10/ 21/20, 10/24/20 and 10/25/20. She reported she was not aware of any open area on Resident #1 prior to 10/25/20. Nurse #3 was interviewed on 2/24/21 at 10:16 AM. Nurse #3 was assigned to Resident #1 on 10/23/20. She reported that she could not remember Resident #1 having a pressure ulcer and she could not recall applying a foam dressing on her sacrum. Nurse #4 was interviewed on 2/24/21 at 10:24 AM. Nurse #4 verified that she was assigned to Resident #1 on 10/22/20. She stated that she could not remember Resident #1 having a pressure ulcer and she could not recall applying a foam dressing on her sacrum. The Director of Nursing (DON) was interviewed on 2/24/21 at 1:00 PM. The DON stated that she was aware of Resident #1's pressure ulcer. Nurse #1, who was assigned to Resident #1 on 10/25/20, conducted the weekly skin check and noted a foam dressing on the resident's sacrum. When she removed the dressing, she noted an open area. Nurse #1 reported that she then informed the treatment nurse. The DON explained the facility's system for notifying the treatment nurse of new open areas was to inform him verbally if in the building or leave a note when he was not available in the building. The DON further stated that she expected the nurse who	F 686	document/notify nursing of resident skin issues. Stop and Watch is an early warning communication tool that Certified Nursing Assistants (CNAs) can use to alert a nurse if they notice something different in a resident's daily care routine. The following items must be completed by CNA when new skin impairments are observed. You must notify the charge nurse that is responsible for that resident You must complete a stop and watch and place in the basket between the DON and RN Supervisor office. The following items need to be on the STOP & WATCH. The nurse name that you reported the skin impairment to The area of the skin impairment CNA's name Date notified Monitoring The DON, RNS and Weekend RN Supervisor will be auditing 100% of Weekly Skin audits and events daily for 2 weeks, 50% weekly for four weeks, then 25% monthly for two months. The DON, RNS and Weekend RN Supervisor will be checking to see that all areas on skin observations and new skin impairment events have a treatment order are in place and the Medical Director and Responsible Parties have been notified.	

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F 686	Continued From page 4 identified the open area to at least obtain a treatment order by following the facility's wound protocol or by calling the doctor. The DON further indicated that LPN could not stage a pressure ulcer but there were registered nurses (RNs) in the building. The Unit Manager (UM) was interviewed on 2/24/21 at 1:08 PM. The UM indicated that Nurse #1 informed her that during her weekly skin check on 10/25/20, Nurse #1 noted a foam dressing on Resident #1's sacrum. When Nurse #1 removed the foam dressing, she noted an open area. The UM indicated that Nurse #1 informed her that she had notified the treatment nurse of the open area on 10/25/20. The UM explained that Nurse #1 was a licensed practical nurse (LPN) and she could not stage a pressure ulcer, but she was expected to get a RN to assess the pressure ulcer when the treatment nurse was not available. She was also expected to follow the facility's wound protocol or call the doctor for treatment order when the treatment nurse was not available.	F 686	QAPI All audits and results will be brought to the monthly QAPI meeting by the DON. QAPI team will review and make changes as needed.	