STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 An unannounced complaint investigation was conducted 10/19/21 through 10/20/21. Event ID# PDGM11. 1 of the 2 complaint allegations were substantiated resulting in a deficiency.	F 000		
F 698 SS=E	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow doctor's orders for preparation for an outpatient procedure that was scheduled on three different dates causing the resident not to be able to have the procedure for each date it was schedule for 1 of 1 resident reviewed for dialysis (Resident #1). Findings included: Resident #1 was admitted to the facility on 10/16/20 with diagnoses that included metabolic encephalopathy, and end stage renal disease. Resident #1's quarterly Minimum Data Set assessment dated 8/24/21 revealed he was cognitively intact and required extensive assistance with activities of daily living. He was also coded for hemodialysis services. Review of records revealed Resident #1's Vascular Specialist office faxed orders to the	F 698	F698 The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. Resident affected: The facility confirmed with Carolina Vascular Access services that no additional appointments have been scheduled at this time. Resident #1 continues to receive dialysis treatments without incident. Resident #1 did not	11/1/21

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

Electronically Signed | 10/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 698	Continued From page 1 facility on 8/5/21 with instructions for a scheduled fistulagram, an x-ray to look at blood flow and check for blood clots or other blockages in the fistula, on 8/17/21 at 7:00 AM. Instructions specified Resident #1 to not eat or drink after midnight on the night before the procedure (NPO), and to take the pre-procedure medications prescribed. The pre-procedure medications were listed as: (1) At 7 pm the night prior to the procedure: Prednisone 40 milligrams (mg) 1 tablet (2) At 11 pm the night prior to the procedure: Prednisone 40 mg 1 tablet (3) Morning of procedure: Prednisone 40 mg 1 tablet and Benadryl 50 mg 1 tablet During an interview with the Director of Nursing (DON) on 10/20/21 at 10:40 am, she revealed she discovered the faxed instructions for Resident #1 from Vascular Specialist office was scanned by the facility's Medical Records personnel on 8/5/21, but the orders were not entered into the system by nursing. Therefore, the orders for the pre-procedure medications and NPO instructions were not carried through on 8/16/21 and 8/17/21. The DON also revealed the same orders and instructions were faxed from Vascular Specialist office for the same procedure scheduled for 9/2/21 at 8:00 AM. These orders were scanned by the facility's Medical Records personnel but not entered into the system by nursing. Resident #1 did not receive the pre-procedure medications or maintain NPO status for the scheduled procedure on 9/2/21. The DON stated that the nurses or nurse managers were responsible to place orders into the system. She further clarified that the orders were not placed into the system because the Medical Records personnel scanned the orders	F 698	suffer any adverse effects secondary to the alleged deficient practice. Others with potential to be affected: On 10/20/2021, the Director of Nursing (DON) completed an audit of all scheduled outpatient procedures for the past sixty (60) days for all residents in the facility. There were no additional missed procedures and no other residents were adversely affected by the alleged deficient practice. Systemic Changes: On 10/21/2021, the DON educated Nurse Manager #1 and Nurse Manager #2 regarding proper procedure and timeliness on transcribing orders into the physician order section of the electronic medical record. On 10/22/2021, the DON educated the Business Office Manager and the Admissions Director that when they receive any physician orders and/or consultation reports, this information will be provided to both Nurse Manager #1 and Nurse Manager #2 and the DON to ensure these orders are transcribed into the physician order section of the EMR timely. The DON and/or designee will educate all clinical nurses on proper procedures for transcribing pre-procedural physician orders and on the administration of pre-procedural medications. This will be completed by 10/29/2021. Any clinical nurse out on leave or PRN status will be educated prior to returning to duty. Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278

(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 698	Continued From page 2 and nursing had not entered them into the system, which caused the pre-procedure medications to not be administered. During a telephone interview with Vascular Specialist office personnel on 10/20/21 at 11:15 am, she revealed Resident #1 had missed four appointments in 2021. The first appointment missed was on 1/2/21 for a follow up from the previous month. The other appointments missed were on 5/7/21, 8/17/21 and 9/2/21 to perform a fistulagram. The procedure was scheduled from the hemodialysis center to ensure the fistula was functioning properly. She clarified the appointments missed on 5/7/21, 8/17/21 and 9/2/21 were because her office had to cancel each scheduled procedure due to the failure of the facility to give Resident #1 the pre-procedure medications for his contrast dye allergy and maintain an NPO status per the instructions. Resident #1 was then sent back to the facility and the procedure was not performed each time. She indicated she was made aware from the nursing department when she called the facility on each of these dates to confirm if Resident #1 had the pre-procedure medications and was NPO the night before that he had not been given the medications and he was not NPO. She also indicated Resident #1 stated when he arrived to each of these appointments that he did not receive the pre-procedure medications for his contrast allergy, and he had eaten breakfast on the mornings of the appointments. She further revealed although the fistulagram was not done it was recommended to reduce complications such as infection During an interview with the Medical Director on 10/20/21 at 2:05 pm, she revealed she was not	F 698	newly hired clinical nurse will be educated on this process during orientation by the Staff Development Coordinator and/or DON. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An audit tool was developed by the Corporate Nurse Manager to audit 100% of all residents with outpatient procedures to ensure transcription and receipt of any pre-procedural physician orders into the physician order section of the electronic health record. These audits will be conducted by the DON and/or designee. These audits will be conducted weekly x 4 weeks, then biweekly x 4 weeks, then monthly x 1 month. The results of these audits will determine the need for further monitoring. The Director of Nursing will bring the results of these audits to the Quality Assurance and Performance Improvement Committee monthly for review and further recommendations. Completion date: Nov 1, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345439	A. BUILDING _____ B. WING _____	C 10/20/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - BROOKSHIRE, INC	**300 MEADOWLANDS DRIVE HILLSBOROUGH, NC 27278**

(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 698	Continued From page 3 aware that Resident #1 had missed any appointments at Vascular Specialist office. She noted that Resident #1 received hemodialysis three times a week and had a contrast dye allergy. She indicated Resident #1 was sent to the hospital on 8/9/21 for acute chest pain during a hemodialysis visit. She stated that she did not think the missed appointments at the Vascular Specialist office contributed to the hospitalization because his fistula site was currently being accessed at the hemodialysis center three times a week with no apparent issues. The Medical Director discussed the usual process of orders received from outside providers and expected the facility's nurses or nurse managers to transcribe and implement accordingly. She stated that she expected nursing personnel to ensure the providers at the facility signed all orders from outside providers before they were scanned by medical records personnel. The Medical Director further stated that she felt there was no harm done, and there was a communication problem that caused the facility to fail to give the pre-procedure medications that resulted in the missed appointments for Resident #1.	F 698		