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 ______	10/19/2022

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 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/17/2022 through 10/19/2022. Event ID# 2K7911. The following intakes were investigated NC00184268, NC00184297, NC00184396, NC00192641, and NC00193868. One of the 18 complaint allegations was substantiated resulting in deficiencies.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		11/8/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 11/08/2022

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 580	Continued From page 1 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff and legal guardian interviews the facility failed to notify the responsible party after a resident was transferred to the hospital for 1 of 3 residents (Resident #4) reviewed for notification. Findings included: Resident #4 was admitted the facility on 4/21/21 with diagnoses which included hypertension and anxiety. Review of the quarterly Minimum Data Set (MDS) dated 8/2/22 revealed Resident #4 was severely cognitively impaired. The MDS further revealed	F 580	Resident affected: Resident #4 was sent to the hospital on 10/4/22 at an estimated 6:00 AM after assessment by the on-call Hospice Nurse. Resident #4’s family was in facility on 10/4/22 after lunch and was informed that resident #4 had been sent to hospital by Hospice. Hospice resident #4 was not adversely affected by the alleged deficient practice. Other residents with potential to be affected: All residents discharged to the hospital in the last 30 days that have the potential to be affected by this alleged deficient	

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F 580	Continued From page 2 Resident #4 was coded for hospice and tube feeding. Review of Resident #4 care plan dated 9/16/22 revealed Resident #4 had behaviors and mood problems which places the resident at risk for injury and/or harm to themselves and others. The goal indicated Resident #4 will have minimal increase in behaviors and will remain free from injury, harm to self and others as evidenced by decreased episodes of physical behavior. Intervention included to notify the medical director (MD) and RP of any significant behaviors or change in condition promptly. Review of progress note by Nurse #3 dated 10/4/22 revealed Resident #4 displaced her g-tube (feeding tube) this morning and an on-call hospice nurse was notified. The note further revealed the on-call hospice nurse completed an assessment and due to the stoma being closed was unsuccessful in reinserting the feeding tube. It was advised to send Resident #4 to the hospital. An interview conducted with Nurse #3 on 10/19/22 at 11:30 AM revealed she worked on 10/4/22 when Resident #4 was sent out to the hospital at an estimated time of 6:00 AM. Nurse #3 further revealed an on-call hospice nurse came to assess Resident #4 and made the decision to send the resident out to the hospital. Nurse #3 indicated she had thought the on-call hospice nurse had contacted the family since she assessed Resident #4. An interview conducted with Nurse #4 on 10/19/22 at 12:30 PM revealed she worked on 10/4/22 during 1st shift when Resident #4	F 580	practice have been audited on 10/20/22 to make sure the responsible party was contacted timely. The audit was conducted by the Director of Nursing (DON) and Charge Nurse on 10/20/22 with no additional residents identified as having been affected by the alleged deficient practice. System changes: The Director of Nursing (DON) and Staff Development Coordinator (SDC) started education on 10/19/22 for Nursing and Hospice staff on the facility policy and procedure for hospital transfers. This education included the facility policy and procedure for notification when resident is discharged. The education was completed on November 8, 2022. Any Nursing or Hospice staff out on leave, vacation or PRN status will be educated on this policy and procedure by the DON or SDC prior to returning to their assignment. All newly hired Nurses or Hospice staff will be educated on this policy and procedure during orientation by the SDC or DON. Monitoring: An audit tool was developed 10/20/22 to ensure compliance with the plan of correction. The Audits will be conducted by the DON, Assistant Director of Nursing (ADON) or SDC to ensure appropriate and timely notification of hospital transfer. 100% of residents transferred to the hospital will be audited for eight weeks. The results of these audits will determine the need for further monitoring. QAPI All audits will be brought to the Quality	

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F 580	Continued From page 3 returned to the facility from the hospital. Nurse #4 stated Resident #4's family representative visited the facility to see the resident and was informed the resident had been sent out to the hospital early that morning. Nurse #4 stated the family representative was upset that she had not been notified. An interview conducted with the family representative on 10/17/22 at 12:20 PM revealed Resident #4 was sent out to the hospital on 10/4/22 and they were not notified. The family representative indicated she had visited the facility on 10/4/22 after lunch and was told by nursing staff that Resident #4 had been sent to this hospital early that morning around 6:00 am. The family representative revealed she had not been notified and was upset because she had attended all doctor and hospital visits with Resident #4. An interview conducted with the Director of Nursing (DON) on 10/19/22 at 4:15 PM revealed she was aware Resident #4's family representative was upset that she had not been notified when Resident #4 had been sent to the hospital. The DON further revealed nursing staff had thought the on-call hospice nurse who assessed the resident was going to notify the family but did not. The DON stated she expected the hospice nurse would have called the family, but it was nursing staff responsibility to make sure that the family was notified.	F 580	Assurance and Performance Improvement (QAPI) Committee monthly by the DON, for review and to ensure continued compliance with the plan of correction.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F 695		11/10/22

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F 695	Continued From page 4 The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interviews with resident and staff the facility failed to administer oxygen as prescribed by the physician for 3 of 3 residents (Resident #1, Resident #2, and Resident #3) reviewed for oxygen therapy. The findings included: 1. Resident #1 was initially admitted to the facility on 07/07/22 with diagnoses that included shortness of breath and obstructive sleep apnea. Resident #1's most recent quarterly Minimum Data Set (MDS) dated 10/07/22 revealed she was alert and oriented. Resident #1 was coded for oxygen use. Resident #1's care plan initiated on 07/12/22 and revised on 10/04/22 indicated Resident #1 had a focus area for oxygenation. Interventions included administer oxygen as need per physician order, monitor oxygen saturations on room air and on oxygen. A physician order dated 07/07/22 for Resident #1 indicated oxygen therapy at 2 liters via nasal cannula continuously.	F 695	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. Resident affected Residents #2 and #3 had portable oxygen tanks replaced on 10/18/2022 by Nurse #1. Oxygen saturation level checked by Nurse #2 for both resident #2 and #3 with both having 100% oxygen saturation levels. Residents #1 had portable oxygen tanks replaced on 10/19/2022 by Nurse #1. Oxygen saturation level checked by Nurse #1 for resident #1 with resident having 96% oxygen saturation level. Residents #2 and #3 were assessed on 10/18/22 and resident #1 on 10/19/22 by Nurse and had no adverse effects by the alleged deficient practice. Residents with the potential to be affected A 100% audit of facility residents on oxygen was conducted by the Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Charge Nurse on 10/19/202. There were no other residents’ empty oxygen tanks. No additional residents were identified as	

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An observation of Resident #1 on 10/19/22 at 9:22 AM revealed the resident sitting in her wheelchair getting ready to leave the facility for a physician's appointment. Resident #1 was wearing a nasal cannula attached to a portable oxygen tank set on 2 liters. The oxygen tanks dial pointed to the red area indicating the tank was on empty and needed to be refilled.

An interview conducted with Resident #1 on 10/19/22 at 9:22 AM revealed she always wore oxygen set at 2 liters via nasal cannula. She stated she normally would get short of breath without oxygen however at the time was not short of breath. Resident #1 stated she thought she saw Physical Therapy Assistant (PTA) #1 who helped her in the wheelchair check the portable tank before leaving the room.

An observation of Resident #1 on 10/19/22 at 9:24 AM revealed a staff member from the transportation company going into the room and removed Resident #1 from her room into the hallway to take her to the scheduled appointment. Resident #1's portable oxygen tank was not checked prior to exiting the room. The surveyor stopped the transportation staff member and asked Nurse #1 to obtain Resident #1's oxygen saturation level and a full portable oxygen tank. Nurse #1 confirmed the oxygen tank on Resident #1's wheelchair was empty. Nurse #1 checked Resident #1's oxygen saturation with an initial reading of 86%. (Normal range for oxygen saturation level is greater than 92%). Nurse #1 then asked Resident #1 to take deep slow breaths and the oxygen saturation level reached 96% once the full oxygen tank was attached to the resident's oxygen tubing.

F 695

having been adversely affected by the alleged deficient practice.

Systemic Changes

The Director of Nursing (DON), Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) will educate oxygen policy and procedure for all Nursing staff, Certified Nursing Assistants, Medication Aides, Medication Technicians, contract staff and Therapy staff starting 10/19/22. This education included the facility policy and procedure for resident oxygen use. Education will be completed by November 10, 2022. Any Nursing staff, Certified Nursing Assistants, Medication Aides, Medication Technicians, contract staff and Therapy staff out on leave, vacation or PRN status will be educated by the DON, ADON or SDC prior to returning to their assignment. All newly hired Nursing staff, Certified Nursing Assistants, Medication Aides, Medication Technicians, contract staff and Therapy personnel will be educated on this policy and procedure during orientation by the SDC or DON.

Monitoring

DON, ADON or SDC to audit (how many residents?) using Peak Oxygen Audit Tool on all shifts randomly twice a week for four weeks and then once weekly for 4 weeks, then biweekly x 4 weeks to ensure continued compliance. The results of these audits will determine the need for further monitoring.

QAPI

All audit information will be brought to the Quality Assurance and Performance Improvement Committee meeting monthly

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F 695	Continued From page 6 An interview was conducted with Nurse #1 on 10/19/22 at 9:45 AM. Nurse #1 stated she was responsible for Resident #1 but had not assisted her into the wheelchair to go to her appointment. She stated she was completing her medication pass and had not gotten to Resident #1 yet to check her oxygen saturation level. Nurse #1 stated it was every staff member's responsibility to check the oxygen tank to ensure the resident had a full tank of oxygen. An interview conducted with the Assistant Director of Nursing (ADON) on 10/19/22 at 9:57 AM revealed there were steps that should have been followed by each staff member that came in contact with the resident. She stated even though the transportation was an agency employee he should have checked the oxygen tank prior to removing the resident from her room. On 10/19/22 at 2:23 PM an interview was conducted with Physical Therapy Assistant (PTA) #1. During the interview she stated that she assisted Resident #1 into the wheelchair earlier in the morning prior to the resident's appointment around 8:30 AM. PTA #1 stated she thought she checked the oxygen tank, and it was a quarter away from being empty. The interview revealed she had tried to conserve oxygen and would wait until the dial was in the red indicating it needed to be refilled before changing the tank. On 10/19/22 at 3:01 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was the staff member who assisted Resident #1 into the wheelchair's ultimate responsibility to ensure the portable	F 695	by the DON to be analyzed and reviewed for further recommendations.	

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F 695	Continued From page 7 oxygen tank was full. She stated it had been overlooked by staff, but she expected all staff members that came in contact with Resident #1 to have checked the oxygen tank. 2. Resident #2 was admitted into the facility on 02/02/22 with diagnosis which included chronic obstructive pulmonary disease, pulmonary fibrosis, and shortness of breath. Resident #2's most recent quarterly MDS dated 07/12/22 revealed she was alert and oriented. Resident #2 was coded for oxygen use. Resident #2's care plan initiated on 05/23/22 indicated Resident #2 had a diagnosis of chronic obstructive pulmonary disease and pulmonary fibrosis which could lead to decreased oxygen saturation levels. Interventions included administer oxygen as need per physician order, monitor oxygen saturations on room air and on oxygen. A physician order dated 03/17/22 for Resident #2 read, "May titrate oxygen to maintain oxygen saturation level greater than 90% as needed. An observation of Resident #2 on 10/18/22 at 3:57 PM revealed she was sitting in her wheelchair in the hallway with an oxygen setting of 1 liter via nasal cannula. The oxygen tanks dial pointed to the red area indicating the tank was on empty and needed to be refilled. An interview conducted with Resident #2 on	F 695		

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10/18/22 at 3:57 PM revealed she always wore oxygen. She stated the only time she removed the oxygen tubing was when she went to take a shower. Resident #2 stated she did not feel short of breath.

On 10/18/22 at 3:59 PM the surveyor asked Nurse #2 if he could observe Resident #2's oxygen tank. Nurse #2 confirmed the tank was empty and needed to be refilled. He stated he was unaware the tank was on empty and checked Resident #2's oxygen saturation level which read 100%.

On 10/19/22 at 3:01 PM an interview was conducted with the Director of Nursing (DON). The DON stated it was the staff member who assisted Resident #2 into the wheelchair's ultimate responsibility to ensure the portable oxygen tank was full. She stated it had been overlooked by staff, but she expected all staff members that came in contact with Resident #2 to have checked the oxygen tank.

3. Resident #3 was admitted into the facility on 11/08/18 and readmitted on 10/17/22 with diagnosis which included acute upper respirator infection.

Resident #3's most recent quarterly MDS revealed she was moderately cognitively impaired. Resident #3 was coded for oxygen use.

Resident #3's care plan initiated on 11/09/18 and revised on 04/26/22 indicated Resident #3 had a focus area related to active intolerance and shortness of breath. Interventions included administer oxygen as need per physician order

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F 695	Continued From page 9 and to monitor oxygen saturations on room air and on oxygen. A physician order dated 10/17/22 for Resident #3 read, "Oxygen at 3 liters via nasal cannula continuously every shift". An observation of Resident #3 on 10/18/22 at 4:10 PM revealed she was sitting in her wheelchair in the hallway with an oxygen setting of 3 liters via nasal cannula. The oxygen tanks dial pointed to the red area indicating the tank was on empty and needed to be refilled. On 10/18/22 at 4:10 PM the surveyor asked Nurse #2 if he could observe Resident #3's oxygen tank. Nurse #2 confirmed the tank was empty and needed to be refilled. He stated he was unaware the tank was on empty and checked Resident #3's oxygen saturation level which read 100%. On 10/18/22 at 4:15 PM an interview conducted with Nurse #2 revealed he was responsible for Resident #3. He stated he had come onto shift at 3:00 PM and had not gotten around to Resident #3 yet. He stated it was every staff members responsibility to check the oxygen tanks on the back of the residents wheelchairs.	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5	F 759		11/7/22

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F 759	Continued From page 10 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, and interviews with staff the facility failed to remain free of a medication error rate of 5% or more when reviewed for medication administration. The findings included: An observation was conducted on 10/19/22 at 8:25 AM of Medication Aide (MA) #1 administering medication on the 500 hall. MA #1 had an order which read, "Calcium 600 milligram (mg) tablet administer 1500 mg once daily in the morning. MA #1 then placed one 600mg tablet into the medication cup and placed the bottle back into the medication drawer. An observation was conducted on 10/19/22 at 8:36 AM of MA #1 having an order which read, "Vitamin B 12 500 microgram (mcg) tablet administer 1,000 mcg tablet once daily". MA #1 then placed one 500 mcg tablet into the medication cup and placed the bottle back into the medication drawer. On 10/19/22 at 8:37 AM an interview was conducted with MA #1. After reviewing the orders for Calcium and Vitamin B12 MA #1 stated she missed giving the correct dosage for both medications because of how the order read. She stated she normally was not working on the 500-medication cart and was not familiar with what medications each resident received. MA #1 stated she had only placed one 600mg tablet of Calcium into the cup and one 500 mcg tablet of Vitamin B12.	F 759	Resident affected: On 10/19/2021, immediate retraining was conducted by the Director of Nursing (DON) with Medication Aide (MA #1) regarding medication administration and correct dosages. Charge Nurse #1, present during the medication observation by surveyor on 10/19/22 at 8:25 AM made dosage correction ensuring the correct dosage of Calcium 1500mg and Vitamin B12 1,000 mcg was administered. There were no residents adversely affected by the alleged deficient practice. Other residents with potential to be affected: Charge Nurse #1 continued with MA #1 for the remainder of medication administration to ensure no other medication dosage errors. At the end of this medication administration, MA #1 was replaced with a Licensed Practical Nurse on the medication cart for medication administration. There were no additional residents identified to have been affected by the alleged deficient practice. System changes: The Director of Nursing (DON), Assistant Director of Nursing (ADON) and Staff Development Coordinator (SDC) will educate all Licensed Nurses and Medication Aides (MA) on medication passes and dosages. This education will be completed by November 10, 2022. Any Licensed Nursing or MA staff out on leave, vacation or PRN status will be educated by the DON, ADON or SDC	

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(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
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An observation was conducted on 10/19/22 at 8:39 AM of MA #1 and Charge Nurse #1 ensuring the correct dosage of Calcium 1500mg and Vitamin B12 1,000 mcg was administered.

An interview conducted on 10/19/22 at 8:40 AM with Charge Nurse #1 revealed MA #1 normally worked on the assisted living side of the facility as a nurse aide. She stated the facility had a nurse that was late, and they had pulled MA #1 to cover the cart.

On 10/19/22 at 3:01 PM an interview was conducted with the Director of Nursing. During the interview she was notified of the medication error rate of 6.67%. She stated she was aware of the two medication errors. The interview revealed MA #1 normally did not work on a medication cart and was not familiar with giving medication on the 500 halls. She stated she would provide an in-service to staff on administering correct dosages.

prior to returning to their assignment. All newly hired Nurses or MA contracted Licensed personnel will be educated on this policy and procedure during orientation by the SDC or DON.
Monitoring:
DON, ADON or SDC to audit using Medication Pass Worksheet for Licensed Nursing and MA staff during medication pass on all shifts randomly twice a week for four weeks and then once weekly for 4 weeks, then biweekly x 4 weeks to ensure continued compliance. The results of these audits will determine the need for further monitoring.
QAPI
All audits will be brought to the Quality Assurance and Performance Improvement (QAPI) Committee monthly by the DON, for review and to ensure continued compliance with the plan of correction.