STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources- Shelby	1101 North Morgan Street Shelby, NC 28150

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Physician Assistant interviews, the facility failed to notify the Physician/Physician Assistant when a resident did not receive a prescribed medication for 1 of 1 resident reviewed for notification (Resident #75).The findings included:Resident #75 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes.Resident #75's physician orders and medication administration record (MAR) revealed the following: On 11/25/25 a physician order was written for semaglutide (0.25 mg or 0.50 mg) to be administered subcutaneously once a week on Mondays.The MAR indicated it was administered on 12/01/25 at 8:00 AM (Nurse #2), was not administered on 12/08/25 due to the resident refused (Nurse #2) and was not administered on 12/15/25 due to awaiting delivery from the pharmacy (Nurse #2). On 12/22/25 semaglutide (0.25 mg or 0.50 mg) was discontinued. A review of Resident #75's medical record revealed there was no documentation indicating the Physician/Physician Assistant had been notified that semaglutide was not administered as ordered.An interview conducted with Nurse #2 on 2/09/26 at 2:04 PM revealed she was assigned to Resident #75 on first shift (7:00 AM to 7:00 PM). Nurse #2 indicated Resident #75 had an order for semaglutide, but it was not available in the medication room on 12/01/25 or 12/08/25 or 12/15/25 and she did not administer the medication. Nurse #2 stated she documented on the MAR in error that she administered the semaglutide on 12/01/25 and that Resident #75 refused the medication on 12/08/25 and she should have documented the medication was not administered because it was unavailable. Nurse #2 indicated she notified the provider when a resident did not receive a prescribed medication, however she did not recall if she notified the Physician Assistant that Resident #75 had not received the semaglutide. An interview conducted with the Physician Assistant on 2/11/26 at 1:25 PM revealed she gave a new order on 11/25/25 for Resident #75 to start semaglutide 0.25 mg to help regulate her blood sugars and assist with weight loss. The Physician Assistant stated she entered the order in the electronic medical record (EMR) and notified Nurse #1 the order was ready to be sent to the pharmacy. The Physician Assistant stated she was not notified that the order sent to the pharmacy did not have the dose of the medication or that the medication was not delivered until 12/29/25. The Physician Assistant revealed there were no adverse outcomes from Resident #75 not receiving the semaglutide starting in November however the facility should have notified her that Resident #75 was not receiving the medication. An interview conducted with the Administrator on 2/11/26 at 3:42 PM revealed the Physician/Physician Assistant should be notified when a resident was not receiving a prescribed medication whether the medication was unavailable or the resident refused to take the medication.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and Pharmacist, Physician Assistant, Medical Director, resident and staff interviews, the facility failed to respond to the pharmacy's request for a corrected physician order with the dosage information of a medication to ensure a resident's medication was obtained and administered as ordered for 1 of 3 residents reviewed for professional standards (Resident #75). The findings included:Resident #75 was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes.The Physician Assistant note dated 11/25/25 revealed Resident #75 was evaluated due to a weight gain of approximately 15 pounds in 3 months. Resident #75 had a diagnosis of type 2 diabetes and was receiving scheduled insulin but was not complying with a diabetic diet which likely contributed to the weight gain. Resident #75 was agreeable to starting semaglutide to help with regulating her blood sugars and to assist with weight loss. A new order was given to start semaglutide 0.25 mg once a week on Mondays.Resident #75's physician orders and Medication Administration Record (MAR) revealed the following: On 11/25/25 a physician order was written for semaglutide (0.25 mg or 0.50 mg) to be administered subcutaneously once a week on Mondays.The MAR indicated semaglutide (0.25 mg or 0.50 mg) was administered on 12/01/25 at 8:00 AM by (Nurse #2), was not administered on 12/08/25 with a note the resident refused (Nurse #2) and was not administered on 12/15/25 due to awaiting delivery from the pharmacy (Nurse #2). On 12/22/25 semaglutide (0.25 mg or 0.50 mg) was discontinued per physician's order. On 12/29/25 semaglutide 0.25 mg was ordered to be administered subcutaneously once a week on Mondays.The MAR indicated semaglutide 0.25 mg was not administered on 1/05/26 or 1/12/26 due to resident refusal (Nurse #2), was administered on 1/19/26 at 8:00 AM (Staff Development Coordinator) and was administered on 1/26/25 at 8:00 AM (Nurse #3).The quarterly minimum data set (MDS) assessment dated [DATE] revealed Resident #75 was cognitively intact, had an active diagnosis of diabetes mellitus, and received insulin injections 7 out of 7 days during the assessment period. The care plan dated 1/30/26 revealed Resident #75 was at risk for hypoglycemic (low blood sugar) and hyperglycemic (high blood sugar) episodes due to a diagnosis of diabetes. The interventions included providing a diabetic snack at bedtime, monitoring for signs of hyperglycemia and hypoglycemia and notifying the physician if blood sugar readings were below 60 or above 450. An interview was conducted with Resident #75 on 2/09/26 at 3:09 PM. Resident #75 revealed on 11/25/25 the Physician Assistant ordered semaglutide to help regulate her blood sugars and assist with weight loss. Resident #75 indicated the medication was not administered until January 2026, but she did not question anyone about the delay because it usually took a while for the facility to get new medications from the pharmacy. Resident #75 stated she did refuse the first two doses of the semaglutide in January because she had a few questions for the Physician Assistant concerning possible reactions. Resident #75 stated the semaglutide was administered as ordered on 1/19/26 and 1/26/26. An interview conducted with Nurse #2 on 2/09/26 at 2:04 PM revealed she was assigned to Resident #75 on first shift (7:00 AM to 7:00 PM). Nurse #2 indicated Resident #75 had an order for semaglutide, but it was not available on 12/01/25 or 12/08/25 or 12/15/25 and was not administered. Nurse #2 stated when a resident's medication was not administered because it was unavailable she notified Nurse #1 and the provider, but she did not recall if she notified them concerning Resident #75 not receiving the semaglutide. Nurse #2 revealed the semaglutide was available on 1/05/25 and 1/12/25 but Resident #75 refused it because she had a few questions for the Physician Assistant concerning possible reactions. Nurse #2 stated she documented on the MAR in error that she administered semaglutide to Resident #75 on 12/01/25 and that it was refused on 12/08/25 and she should have documented on the MAR that the medication was unavailable.An interview conducted with Nurse #1 on 2/11/26 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 8:56 AM revealed she was the first shift (7:00 AM to 3:00 PM) unit manager. Nurse #1 stated when a resident had a new medication order it was entered into the electronic medical record (EMR), verified and then sent electronically to the pharmacy. Nurse #1 revealed the Physician Assistant entered an order in the EMR on 11/25/25 for Resident #75 to start semaglutide. Nurse #1 indicated she verified the order in the EMR and sent it to the pharmacy on 11/28/25. Nurse #1 stated she was not aware the dose of semaglutide was not on order or that the pharmacy needed the order to be clarified. During a phone interview with the Pharmacist on 2/11/26 at 1:48 PM he revealed the facility sent an order on 11/25/25 for Resident #75 to start semaglutide but the order did not include the dosage information. He stated the Former Director of Nursing (DON) was notified on 11/25/25, 12/03/25, 12/17/25 and 12/22/25 that the order needed to be resent with the dosage information so the pharmacy could dispense and deliver the medication. The Pharmacist revealed the facility sent a new order on 12/29/25 for semaglutide 0.25 mg to be administered subcutaneously once a week and the medication was delivered to the facility on [DATE].Several attempts made to contact the Former DON were unsuccessful.An interview conducted with the Physician Assistant on 2/11/26 at 1:25 PM revealed she evaluated Resident #75 on 11/25/25 due to a weight gain of approximately 15 pounds in three months. The Physician Assistant revealed she consulted with the Medical Director, and he agreed with starting semaglutide, so she entered the order in the EMR on 11/25/25. The Physician Assistant stated she was not notified the pharmacy needed the order for semaglutide to be clarified, or that Resident #75 was not administered the medication until 1/19/26. The Physician Assistant stated there were no adverse outcomes from Resident #75 not starting semaglutide however resident medications should be administered as ordered. During a phone interview with the Medical Director on 2/11/26 at 1:14 PM he revealed the Physician Assistant did consult him regarding Resident #75's weight gain and varying blood sugars and he agreed with starting semaglutide. The Medical Director stated Resident #75 not receiving the semaglutide would not have caused an adverse outcome however resident medications should be administered as ordered.An interview conducted with the Administrator on 2/11/26 at 3:42 PM when the pharmacy notified the Former DON the order sent for Resident #75 to start semaglutide did not include the dosage information, she should have clarified the order with the Physician Assistant and sent the updated order to the pharmacy. The Administrator indicated medications should be obtained from the pharmacy and administered to the residents as ordered by the physician.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and resident and staff interviews, the facility failed to ensure a resident's toenails were trimmed and podiatry services were arranged for 1 of 3 residents reviewed for foot care (Resident #63). Finding included: Resident #63 was admitted on [DATE] with diagnoses that included coronary artery disease (CAD), hypertension, diabetes mellitus and cerebrovascular accident (CVA). Resident #63's care plan revised on 12/07/25 revealed Resident #63 was care planned for activities of daily living (ADL) care. The goals included extensive and total staff assistance in all aspects of daily care to ensure all needs were met. Interventions included staff assistance with grooming and personal hygiene. Resident #63 was noted to walk independently with a cane. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #63's cognition was assessed as moderately impaired and he was independent with upper and lower body dressing, putting on/taking off footwear and personal hygiene. Resident #63 was coded as independent for ambulation with use of a walker as a mobility device. He was not coded for rejection of care during the assessment period. Resident #63's most recent weekly skin assessment completed by Nurse #1 dated 02/05/26 revealed no notation that the resident's toenails were long, thick and needed trimming or a referral for podiatrist's care. Review of the facility's podiatry clinic schedule for February 2026 revealed Resident #63 was not scheduled to be seen by the podiatrist. Resident #63's medical record from admission through 02/11/26 revealed no consultation reports or notations in Resident #63's medical record that he had been seen by a podiatrist. An observation and interview were conducted with Resident #63 on 02/08/26 at 11:37 AM. During the interview he removed his socks and showed the surveyor his toenails on the left foot. The toenails were observed to be thick and long extending past his toenail bed. Resident #63 stated, When I put my shoes on it hurts, I need them cut. When the surveyor asked Resident #63 if he had told a staff member he stated, Oh, I don't want to bother them, but they've seen. On 02/10/26 at 2:45 PM an observation of Resident #63's left foot toenails was conducted with Nurse #1. Resident #63's toenails were observed to be thick and long. The left hallux (innermost digit of the foot) toenail was curved to the side. Resident #63 stated to Nurse #1 that he was having some discomfort when he walked and while putting his shoes on. An interview was conducted with Nurse #1 on 02/10/26 at 2:50 PM. During the interview she stated she had conducted the resident's weekly skin assessment on 2/05/26. She stated she noticed his toenails were long at that time but didn't document it because the resident didn't have any complaints about them. Nurse #1 stated she felt like Resident #63 needed a podiatry consult after observing his toenails with the surveyor. An interview was conducted with Nurse Aide (NA) #1 on 02/10/26 at 2:52 PM. She stated she was responsible for Resident #63 during the 7:00 AM to 7:00 PM shift. NA #1 stated she had not seen the residents' toenails because he was always wearing his socks, which he applied independently. The interview revealed Resident #63 wanted to take his own baths in his room. Staff would provide set-up assistance only. She explained Resident #63 would also dress himself, so she had not seen his toenails, nor had he mentioned he was experiencing discomfort with the length of his toenails. An interview was conducted with NA #2 on 02/11/26 at 12:05 PM. During the interview she stated she had provided Resident #63 with set-up assistance for a bath on 2/08/26. She stated she did not observe Resident #63's toenails while caring for him because he dressed himself. An observation was conducted on 02/11/26 at 4:39 PM with the Wound Care Nurse. The Wound Care Nurse was observed measuring Resident #63's toenails on the left foot. The length of the toenail measurements were as follows: hallux 3 centimeters (cm), index (second) 1.9 cm, middle 1.6 cm, ring (fourth) 1.4 cm, and pinky (fifth) 1.1 cm. The Wound Nurse stated, his toenails are long and need to be trimmed by the podiatrist. An interview was conducted with the Director of Nursing (DON) (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 02/11/26 at 2:46 PM. The DON stated the NAs should have been alerting the nurses and the nurses should have assessed Resident #63's toenails during weekly skin assessments. She stated if the nursing staff thought Resident #63's toenails were too long, they could have placed him on the podiatry list and obtained consent from the Responsible Party. The DON indicated she expected all residents to receive podiatry services when needed. An interview was conducted with the Administrator on 02/11/26 at 10:24 AM. The Administrator stated nobody had mentioned to her that Resident #63's toenails were long nor had he come to her and voiced concerns regarding his toenails hurting or difficulty ambulating. The Administrator stated normally the nurses were very good about following through if a resident needed to be seen by the podiatrist. The Administrator indicated she expected all residents to receive podiatry services when needed and Resident #63 would be receiving services moving forward.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and Pharmacist interviews, the facility failed to ensure a prescription that was sent to the pharmacy to be filled contained complete prescribing information for a diabetic medication so that the prescription could be filled and further failed to respond to attempts by the pharmacy to reach the facility to get a corrected physician order for 1 of 5 residents (Resident #75) reviewed for pharmacy services. The findings included:Resident #75 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes.The Physician Assistant note dated 11/25/25 revealed Resident #75 was evaluated due to a weight gain of approximately 15 pounds in 3 months. Resident #75 had a diagnosis of type 2 diabetes and was receiving scheduled insulin but was not complying with a diabetic diet which likely contributed to the weight gain. Resident #75 was agreeable to starting semaglutide (medication used to control diabetes and to lose weight) to help with regulating her blood sugars and to assist with weight loss. A new order was given to start semaglutide 0.25 mg once a week on Mondays.Review of a physician order dated 11/25/25 read; semaglutide (0.25 mg or 0.50 mg) to be administered subcutaneously once a week on Mondays and the order was discontinued on 12/22/25. The MAR indicated the medication was administered on 12/01/25 at 8:00 AM (documented it was given in error by Nurse #2), was not administered on 12/08/25 due to resident refusal (Nurse #2) and was not administered on 12/15/25 due to awaiting delivery from the pharmacy (Nurse #2).An interview conducted with Nurse #2 on 2/09/26 at 2:04 PM revealed she was assigned to Resident #75 from 7:00 AM to 7:00 PM as needed to assist with medication administration. Nurse #2 indicated on 12/01/25 or 12/08/25 or 12/15/25 she did not administer the semaglutide to Resident #75 because it was not available in the medication room. Nurse #2 revealed when a medication was unavailable for a resident, she sent a refill request to the pharmacy in the electronic medical record (EMR) and notified Nurse #1 and the provider if the resident missed a dose of the medication. Nurse #2 stated because the semaglutide was a new medication order she just thought it had not been delivered yet and she did not call the pharmacy to check on the status. Nurse #2 revealed she did not recall if she notified the Physician Assistant that Resident #75 had not received the semaglutide, but Nurse #1 was aware.An interview conducted with Nurse #1 on 2/11/26 at 8:56 AM revealed she was the unit manager from 7:00 AM to 3:00 PM. Nurse #1 stated when a resident had a new medication order it was entered, verified and sent to the pharmacy in the EMR. Nurse #1 revealed the Physician Assistant entered the order for Resident #75 to start semaglutide in the EMR on 11/25/25. Nurse #1 indicated she verified the order in the EMR and sent it to the pharmacy on 11/28/25. Nurse #1 stated she was not aware the order for semaglutide did not have the complete dosage information or that the pharmacy requested a new order. Nurse #1 revealed she thought Resident #75's semaglutide was not delivered because it was unavailable, but she did not follow up with the pharmacy to check on the status of the medication.During a phone interview with the Pharmacist on 2/11/26 at 1:48 PM he revealed the facility sent an order on 11/25/25 for Resident #75 to start semaglutide but the order did not include the complete dosage information. He stated the pharmacy attempted to call the facility, sent a fax notification and emailed the Former Director of Nursing (DON) and the Administrator on 11/25/25, 12/03/25, 12/17/25 and 12/22/25 that the semaglutide order for Resident #75 needed to be clarified so the medication could be dispensed and delivered to the facility. The Pharmacist revealed the facility responded to the pharmacy's requests and sent a new order for the semaglutide with the dosage information on 12/29/25 and the medication was delivered to the facility the same day.An attempt made to contact the Former DON on 2/11/26 at 1:55 PM was unsuccessful.An interview was conducted with the Administrator on 2/11/26 at (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:42 PM. She revealed the Former DON's last day working at the facility was on 1/23/26. The Administrator stated she had not received an email from the pharmacy in November 2025 or December 2025 that a medication order for Resident #75 needed to be clarified and she could not say if the Former DON received the email or if she was aware. The Administrator indicated when a medication was not available the assigned nurse, Nurse#1 and/or the DON should contact the pharmacy to check on the status of the medication or send a refill request in the EMR to ensure medications were available and administered to the residents as ordered by the physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and Pharmacist interviews, the facility failed to remove an expired medication stored in 1 of 1 medication room refrigerator reviewed for medication storage (Medication room [ROOM NUMBER])The findings included:An observation of Medication room [ROOM NUMBER] was conducted on 2/9/2026 at 11:52 AM in the presence of Medication Aide (MA) #1. The following medication was found in the medication room refrigerator in a locked bin: one vial of Lorazepam 2 mg/ml (milligrams/ milliliter). The expiration date on the vial was August 2025 and was not opened. MA #1 confirmed the expiration date by reading aloud the date printed on the vial.An interview with the MA #1 was completed on 2/9/2026 at 11:53 AM. MA #1 stated that she was not sure who would check the medication room for expired medications and thought it was a night shift staff member that checked the temperature for the refrigerator. MA #1 reported that the Pharmacist would check the medication room monthly but would need to confirm with the Director of Nursing (DON).The interview conducted with the DON on 2/11/2026 at 2:50 PM revealed that the Pharmacist visits the facility once per month to check for expired medications. The DON reported once a medication was discontinued the nurse should have removed the medication from the cart or refrigerator and placed the medication in pharmacy container for medications to be returned to the pharmacy.An interview was completed with the Administrator on 2/11/2026 at 3:30 PM. The Administrator stated that expired medication should be sent back to pharmacy. The Administrator reported that each nurse should check medication orders each shift and send back discontinued medication to the pharmacy. The Administrator stated that she expected staff to check carts for expired and discontinued medications prior to dispensing medications to residents.A phone interview was completed with the Pharmacist on 02/11/2026 at 4:47 PM. The Pharmacist stated that he visits the facility once a month to complete medication administration observations with medication aides and nurses. The Pharmacist also reported that he had a team member that would visit the facility every other month to check the medication room for expiredmedications and medications that required more stock. The Pharmacist stated that he would check the medication in the medication carts during the medication administration observations for expired medications. The Pharmacist stated that the facility should not rely on pharmacy visits to review medication stock for expired medication because his team may not check the medication stock every month.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff, resident and pharmacist interviews, the facility failed to maintain accurate records related to medication administration for 1 of 1 resident reviewed for accurate medical records (Resident #75).The findings included: Resident #75 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes. Resident #75's physician orders and Medication Administration Record (MAR) revealed the following: 11/25/25 semaglutide (0.25 mg or 0.50 mg) to be administered subcutaneously once a week on Mondays. The MAR indicated semaglutide was administered on 12/01/25 at 8:00 AM (Nurse #2), was not administered on 12/08/25 with a note the resident refused (Nurse #2) and was not administered on 12/15/25 due to awaiting delivery from the pharmacy (Nurse #2). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #75 was cognitively intact. An interview was conducted with Resident #75 on 2/09/26 at 3:09 PM. Resident #75 revealed on 11/25/25 the Physician Assistant ordered semaglutide to help regulate her blood sugars and assist with weight loss. Resident #75 indicated the medication was not administered until January 2026. An interview conducted with Nurse #2 on 2/09/26 at 2:04 PM revealed she was assigned to Resident #75 on first shift (7:00 AM to 7:00 PM). Nurse #2 indicated Resident #75 had an order for semaglutide, but it was not available on 12/01/25 or 12/08/25 or 12/15/25 and was not administeredNurse #2 stated she documented on the MAR in error that she administered semaglutide to Resident #75 on 12/01/25 and that it was refused on 12/08/25 and she should have documented on the MAR that the medication was unavailable. During a phone interview with the Pharmacist on 2/11/26 at 1:48 PM he revealed the facility sent an order on 11/25/25 for Resident #75 to start semaglutide but the order did not include the dosage information. The Pharmacist revealed the facility sent a new order on for semaglutide 0.25 mg and the medication was delivered to the facility on [DATE]. Several attempts made to contact the Former DON were unsuccessful. An interview conducted with the Administrator on 2/11/26 at 3:42 PM revealed she was not aware that Resident #75 was not administered semaglutide as ordered because it was not delivered by the pharmacy and unavailable. The Administrator stated when a medication was not administered it should be documented accurately in the resident record and on the MAR.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observations and staff interviews, the facility failed to follow their infection control policy for three residents (Resident #4, Resident #62 and Resident #103) when the Treatment Nurse failed to change her gloves and perform hand hygiene during wound care. This deficiency occurred for 1 of 3 staff members reviewed for infection control practices (Treatment Nurse). The findings included: A review of the facility's policy titled Infection Prevention and Control Program, reviewed and revised on 10/28/24, indicated: Gloves must be worn when handling blood and/or other potentially infectious material and if the employee has non-intact skin. Touch clean body sites or surfaces before you touch dirty or heavily contaminated areas. If gloves become torn or heavily soiled and additional resident care tasks must be performed, then change the gloves before starting the next task. Always change gloves after use on each resident and discard them in the nearest appropriate receptacle. Perform hand hygiene before and after donning gloves. 1. An observation of wound care for Resident #4 by the Treatment Nurse was made on 2/10/26 at 9:30 AM. The Treatment Nurse was already in the resident's room when the surveyor entered the room and was observed with a gown already on. The Treatment nurse sanitized her hands and donned clean gloves. The dressing was already removed from Resident #4's wound. The Treatment Nurse stated the dressing had come off during incontinence care earlier that morning. She proceeded to clean the pressure ulcer to Resident #4's coccyx with gauze soaked with wound cleaner. While wearing the same gloves the Treatment Nurse then applied Santyl (ointment used to remove dead tissue) ointment, wet to moist Dakin's (antiseptic wound cleaning solution) solution and packed the wound bed. She then applied a super absorbent pad over it. The Treatment Nurse then collected all of her supplies and threw them into the trash can. The Treatment Nurse doffed her gown, gloves and washed her hands with soap and water. An interview with the Treatment Nurse on 2/11/26 at 1:03 PM revealed she knew she was supposed to change her gloves and sanitize her hands after cleaning Resident #4's wound and before applying the new clean dressing, but she got nervous about being observed during the wound care and forgot this step. The Treatment Nurse stated, I had some training on infection control, but it obviously wasn't enough. An interview with the Infection Preventionist (IP) on 2/11/26 at 1:50 PM revealed the Treatment Nurse should have changed her gloves and washed her hands after cleaning Resident #4's wound and before applying the clean dressing. An interview with the Director of Nursing (DON) on 2/11/26 at 2:47 PM revealed the Treatment Nurse should have changed her gloves and performed hand hygiene before putting a new dressing on Resident #4's wound. The DON stated that the Treatment Nurse needed re-education on infection control and hand hygiene. 2. An observation of wound care for Resident #62 by the Treatment Nurse was made on 2/10/26 at 12:47 PM. The Treatment Nurse donned a clean gown and clean gloves. She then removed the old dressing from Resident #62's right ankle. She proceeded to clean the wound to Resident #62's right ankle with gauze soaked with wound cleaner. While wearing the same gloves the Treatment Nurse then applied a (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. Building B. Wing	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources- Shelby	1101 North Morgan Street Shelby, NC 28150

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	xeroform petrolatum dressing (mesh dressing impregnated with petrolatum). She then collected all of her supplies and threw them into the trash can. The Treatment Nurse doffed her gown, gloves and washed her hands with soap and water. An interview with the Treatment Nurse on 2/11/26 at 1:03 PM revealed she knew she was supposed to change her gloves and sanitize her hands after cleaning Resident #62's wound and before applying the new dressing, but she got nervous about being observed during the wound care and forgot this step. The Treatment Nurse stated, I had some training on infection control, but it obviously wasn't enough. An interview with the Infection Preventionist (IP) on 2/11/26 at 1:50 PM revealed the Treatment Nurse should have changed her gloves and washed her hands after cleaning Residents #62's wounds and before applying the clean dressing. An interview with the Director of Nursing (DON) on 2/11/26 at 2:47 PM revealed the Treatment Nurse should have changed her gloves and performed hand hygiene before putting a new dressing on Resident #62's wound. The DON stated that the Treatment Nurse needed re-education on infection control and hand hygiene. 3. An observation of wound care for Resident #103 by the Treatment Nurse was made on 2/10/26 at 10:30 AM. The Treatment Nurse entered the room after putting a gown on. She washed her hands and put gloves on. She removed the dressing from Resident #103's right heel pressure ulcer. The Treatment Nurse took her gloves off and rubbed hand sanitizer to both hands. She then applied another set of gloves and proceeded to clean the ulcer with gauze soaked with wound cleaner. Without removing gloves and performing hand hygiene, the Treatment Nurse patted the ulcer with a dry gauze and applied collagenase ointment using a cotton swab to the wound bed. She then covered the wound with calcium alginate, applied an abdominal pad over it and wrapped the right foot with a woven gauze bandage. She removed both gloves and applied hand sanitizer to both hands. She donned a new set of gloves and removed the dressing from Resident #103's left foot. Resident #103 had a surgical wound on his left foot which had staples from where his toes were amputated. The Treatment Nurse removed her gloves and rubbed hand sanitizer to both hands before applying another set of gloves. She then cleaned the wound with gauze moistened with wound cleaner. Without removing gloves and performing hand hygiene, the Treatment Nurse covered the wound with an abdominal pad and wrapped Resident #103's left foot with a woven gauze bandage. She then removed her gloves and washed her hands with soap and water at the sink inside the room. An interview with the Treatment Nurse on 2/11/26 at 1:03 PM revealed she knew she was supposed to change her gloves and sanitize her hands after cleaning Resident #103's wounds and before applying the dressing, but she got nervous about being observed during the wound care and forgot this step. The Treatment Nurse stated that she had some training on infection control, but it obviously wasn't enough. An interview with the Infection Preventionist (IP) on 2/11/26 at 1:50 PM revealed the Treatment Nurse should have changed her gloves and washed her hands after cleaning Resident #103's wounds and before applying the dressing. An interview with the Director of Nursing (DON) on 2/11/26 at 2:47 PM revealed the Treatment Nurse should have changed her gloves and done hand hygiene before putting new dressings on Resident #103's wounds. The DON stated that the Treatment Nurse needed re-education on infection control and hand hygiene.