STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345337	A. Building B. Wing	07/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources - Alamance, Inc	215 College Street Graham, NC 27253

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, and resident, Nurse Practitioner (NP), and staff interviews, the facility failed to provide a safe transfer for 1 of 3 residents reviewed for preventing avoidable accidents (Resident #1). On 06/19/2026 (exact time unknown), Resident #1 was in her room with Nurse Aide (NA) #1 and NA #2. NA #2 stood at the side of her bed preparing to assist with transferring. Resident #1 reported that she tried to tell NA #2 that she did not have strength in her back, that she would need the arm rail to assist with getting up, and that she could not lift her arms above her shoulders. NA #2 assured her, then wrapped her arms around Resident #1's torso and lifted her off the bed. Resident #1 stated that her feet were not touching the floor, and she told NA #2 that the action was hurting her. NA #2 reassured her again and placed her in the wheelchair. Resident #1 stated that her right arm hit the arm of the wheelchair during the transfer and was forced straight upward. Resident #1 reported feeling pain and hearing a popping sound in her arm when it was hit. She attempted to tell NA #2 what had happened but became dizzy and lightheaded and could not communicate. Resident #1 was evaluated by Nurse #1, who ordered an X ray of Resident #1's shoulder. The X ray revealed that Resident #1 had a potential fracture in her shoulder, which was confirmed during an emergency room visit on 06/20/2026. She was admitted back to the facility on [DATE] with her right arm in a sling and a prescription for hydrocodone as needed for five days.The findings included:Resident #1 was admitted to the facility on [DATE] with acute chronic diastolic congestive heart failure (a condition where the heart has difficulty relaxing and filling with blood). She also had chronic respiratory failure with hypoxia (longˆterm trouble breathing with low oxygen levels). Her medical history included a personal history of pulmonary embolism (blood clots in the lungs), obesity, and unspecified pain. She also had polyneuropathy (nerve damage causing weakness or numbness).On 06/05/2026, a Physical Therapy Treatment Order was written for Resident #1. The order required physical therapy five times weekly for four weeks to work on therapeutic exercises, therapeutic activities, neuromuscular reeducation (helping improve balance, coordination, and movement), group or concurrent treatment, gait training (improving walking patterns, speed, and safety), and discharge planning.A review of the physical therapy evaluation and plan of treatment for the certification period 06/05/2026 through 07/04/2026 showed Resident #1 had a shortˆterm goal to improve her ability to safely transfer from lying on her back to sitting on the side of the bed with no back support, supervision, or touching assistance. At that time, she required partial to moderate assistance for lyingˆtoˆsitting transfers. A second shortˆterm goal stated Resident #1 would improve her ability to safely transfer to a standing position from sitting in a chair, wheelchair, or on the side of the bed, with no supervision or touching assistance and without abnormal changes in vital signs. She required partial to moderate assistance for sitˆtoˆstand transfers. Resident #1's functional mobility assessment indicated she required partial to moderate assistance for sitˆtoˆstand transfers. The clinical impression stated, based on examination of Resident #1's body regions, systems, and structures, she had balance deficits, decreased dynamic and static balance (difficulty maintaining balance while moving and while still), decreased functional capacity, muscle disuse atrophy (loss of muscle from inactivity), impaired (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	postural alignment control (difficulty sitting or standing upright), proximal instability (weakness in the hips, pelvis, or trunk), and strength impairments. Considering her history, personal factors, and functional limitations, the therapist determined Resident #1 required skilled physical therapy services to analyze her gait (walking) patterns, assess functional abilities, plan discharge needs, improve independence with mobility, improve dynamic balance, increase activity tolerance, increase range of motion and strength in her left arm and leg, reduce fall risk, and improve safety awareness. Resident #1 experienced oxygen desaturation (drop in oxygen levels) during movement and needed increased recovery time afterward, even with encouragement to breathe through her nose. She was functioning below her usual baseline and would benefit from physical therapy to improve strength, mobility, and activity tolerance. A Care Plan dated 06/08/2026 identified a problem titled Plan of Care Resident Profile. The goal stated Resident #1 would have access to necessary care and services to support her quality of life and overall wellˆbeing. The plan stated she required oneˆperson assistance for bed mobility, twoˆperson assistance for standˆpivot transfers, and oneˆperson assistance for wheelchair mobility. This information appeared in her resident profile.Resident #1's profile in the electronic medical record (EMR) was updated on 06/08/2026 to reflect that she required oneˆperson assistance for bed mobility and twoˆperson assistance for standˆpivot transfers.The admission Minimum Data Set (MDS), completed on 06/10/2026, showed Resident #1 was cognitively intact and was working with Speech Therapy, Occupational Therapy, and Physical Therapy.On 09/30/2028 at 10:51 AM, Resident #1 was interviewed and stated that, when prompted, her regular nursing assistant (NA #1) and another nursing assistant she did not know (NA #2) came to get her up for therapy. She stated that NA #2 stood at the side of her bed while NA #1 stood at the end of the bed. She reported that she tried to tell NA #2 that she did not have strength in her back, that she would need the arm rail to assist with getting up, and that she could not lift her arms above her shoulders. NA #2 told her, I've been doing this for 16 years, and I'll get you up, then wrapped her arms around Resident #1's torso and lifted her off the bed. Resident #1 stated that her feet were not touching the floor, and she told NA #2 that the action was hurting her. NA #2 told her to hang on and placed her in the wheelchair. Resident #1 stated that her right arm hit the arm of the wheelchair during the transfer and was forced straight upward. Resident #1 reported feeling pain and hearing a popping sound in her arm when it was hit. She attempted to tell NA #2 what had happened but became dizzy and lightheaded and could not communicate. Resident #1 stated the next thing she knew, she was back in bed with NA #1 and Nurse #1 next to her, and NA #2 standing at the end of the bed.On 06/30/2026 at 2:04 PM, Nurse #1 was contacted by phone but the attempt to speak with him was unsuccessful.On 06/30/2026 at 2:05 PM, NA #2 was contacted by phone but the attempt to speak with her was unsuccessful.On 07/01/2026 at 1:30 PM, NA #1 was interviewed in person and reported that she kept a coded notebook for her assignments, transfer information, and other important details. Without prompting, she began discussing Resident #1. She stated that before she could act, NA #2 had transferred Resident #1 improperly. NA #1 explained that she normally worked at Nursing Station 3, so she allowed NA #2 to take the back half of the hallway because those residents were more cognitively intact. She stated that she was assisting because Resident #1 required a twoˆperson assist. Resident #1 insisted on getting up, and NA #1 tried to persuade her to wait until it was safer; however, when the resident continued to insist, NA #1 moved to the left side of the bed to lower the mattress. As she was about to do this, NA #2 told the resident to lift her arms and wrap them around her neck. Resident #1 informed NA #2 that her arms did not lift above her shoulders. NA #2 insisted, and when the resident attempted to comply, NA #2 wrapped her arms under the resident's underarms and pulled her off the bed. NA #1 reported hearing several popping sounds and hearing the resident express pain. Once the resident was placed in her wheelchair, NA #1 went to get the nurse (Nurse #1), who assessed the resident and reported that she did not immediately send her to the hospital but ordered an Xˆray. NA #1 stated that she reported the incident to the Director of Nursing (DON) and Administration and wrote a statement. She added that NA #2 was terminated following the incident.A (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	progress note written by Nurse #1 on 06/19/2026 at 3:56 PM stated Resident #1 was awake and alert in bed with no signs of acute distress. She denied any needs or complaints. She became short of breath with exertion but recovered quickly and had no shortness of breath at rest. She required oneˆperson assistance for activities of daily living (ADLs) and twoˆperson assistance for bed mobility. At 4:00 PM, another note written by Nurse #1 stated Resident #1 was in bed with a family member present and reported pain in her right shoulder and elbow. Staff noted no swelling, discoloration, or open areas. She could not perform range of motion of her right shoulder because of pain. Her family member reported she had bone fusions and very brittle bones. The family member requested Xˆrays, and Resident #1 agreed. Staff obtained the order and notified the mobile Xˆray service.An Event Report written by Nurse #1 at 6:09 PM on 06/19/2026 stated Resident #1 reported unusual pain in her right shoulder and elbow. Staff administered asˆneeded Tylenol and ordered Xˆrays. Staff notified the Attending Physician and Resident #1's representative at 9:57 PM.A Medical Doctor (MD) progress note on 06/20/2026 at 2:00 PM stated that Resident #1 complained of severe right shoulder pain with limited range of motion (ROM), meaning she could not move her shoulder normally. She had chronic limited ROM in her right shoulder. She reported that the previous day she was moved from her bed to her wheelchair, and afterward she began experiencing pain in the right shoulder area, which was worse the next morning. An Xˆray was completed and showed an abnormality in her right shoulder joint with malalignment (the bones not lining up correctly) of the right humerus (the upper arm bone), which could indicate a fracture. The onˆcall medical provider stated Resident #1 needed to be seen by orthopedics (a medical specialty that treats bone, joint, and muscle problems). The diagnostic assessment and plan stated that Resident #1 had right shoulder pain as her primary issue. The Xˆray showed malalignment of the right shoulder and humerus. The provider documented this as an acute new problem and noted that her condition was worsening. The provider ordered Resident #1 to be taken to the Emergency Department (ED). At 2:56 PM, a progress note stated that the Xˆrays were completed because of her pain. The onˆcall medical provider viewed the Xˆrays while the technician was still in the room. The onˆcall medical provider stated that the images showed a fracture and ordered Resident #1 to be sent to the emergency room (ER) for an orthopedic evaluation. Resident #1's family member was notified and stated she would meet Resident #1 at the ER. Emergency Medical Services (EMS) left the facility with Resident #1 at 2:45 PM.Emergency Department records dated 06/20/2026 at 3:15 PM stated Resident #1, an 89ˆyearˆold woman with chronic respiratory failure, congestive heart failure, prior deep vein thrombosis (DVT), chronic kidney disease, hypertension, and high cholesterol, arrived with a suspected shoulder injury. She reported that two days earlier, during physical therapy, she had been treated roughly and then developed shoulder pain. EMS reported earlier imaging showed a shoulder fracture. Her exam showed tenderness, decreased movement, chronic bruising, and intact circulation and sensation. A new Xˆray showed a proximal humerus fracture. Orthopedics recommended a sling and outpatient followˆup and did not feel surgery was appropriate. Resident #1 understood the plan and received pain medication.A progress note written by Nurse #1 on 06/20/2026 at 6:01 PM stated that Resident #1 returned from the Emergency Department (ED) after being evaluated for a right shoulder fracture. Resident #1 came back with her right arm in a sling and was instructed to wear it at all times. The provider also wrote an order for Hydrocodone as needed (PRN) for five days. Resident #1 received an emergency dose from the facility's emergency supply.On 07/01/2026 at 8:48 AM, the Director of Rehabilitation was interviewed in person and stated that Resident #1 was recommended to receive twoˆperson assistance with pivot turns for safety. She explained that Resident #1's biggest challenge was activity intolerance, as the resident needed a break after completing one step of a multiˆstep task. The Director of Rehabilitation described the process for informing direct care staff of a resident's transfer status: first, an order was obtained and the resident was assessed; next, a verbal recommendation was given to the staff assigned to that resident; and finally, the information was provided to the Minimum Data Set (MDS) Nurse so the resident's profile could be updated in the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	electronic medical record (EMR). She added that part of direct care staff training required staff to check the resident's profile before completing any transfers.On 07/01/2026 at 2:51 PM, NP #1 was interviewed in person and stated that she was not sure what had happened because she was not in the building at the time and the onˆcall provider had been contacted. However, she reported that she spoke with Resident #1 when the resident returned from the hospital. NP #1 stated that Resident #1 reported that NA #2 had been rough with her during a transfer. NP #1 added that she informed the Director of Nursing and the Administrator of the concern after receiving the report.On 07/01/2026 at 2:40 PM, the Administrator was interviewed and reported that the expectation for NAs was to review the resident profile in the EMR system before completing a transfer and before reporting to the floor for their shift. She stated that, after discussing the incident with NA #2, she believed the event was an accident and that NA #2 felt rushed by Resident #1, who was pressing for a transfer. The Administrator reported that NA #2 was terminated following the incident.On 07/01/2026 at 2:52 PM, the Director of Nursing was interviewed and stated that the expectation was for nursing assistants to review the resident profile prior to performing a transfer and to follow the instructions exactly as documented. She reported that NA #2 had completed the orientation process, was aware of the resident profile and transfer status, and nonetheless performed an inappropriate transfer that resulted in Resident #1 being hurt. She added that NA #2 had a brief lapse in judgment and felt pressured by the resident to complete the transfer. The facility provided the following Corrective Action Plan:1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.The resident involved in the incident on 6/19/2026 was immediately assessed following the transfer after reporting shoulder pain. The physician and responsible party were notified, and the resident was transferred for further medical evaluation, which confirmed a fracture. Upon return to the facility, the resident's condition was monitored, appropriate treatment was implemented, and the resident's care plan and transfer interventions were reviewed and revised as indicated to accurately reflect the resident's current needs.The staff member involved was removed from resident care responsibilities pending investigation and was subsequently terminated for failure to follow the resident's established transfer interventions in accordance with facility policy.2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.On 6/22/2026, the Director of Nursing (DON) and Nurse Supervisors completed a 30-day retrospective review of resident injuries requiring physician notification or hospital evaluation to determine whether any injuries may have been associated with resident transfers or failure to follow established transfer interventions. No additional injuries related to improper transfer techniques were identified.Also on 6/22/2026, the Director of Nursing (DON) and Nurse Supervisors reviewed the care plans, resident care guides, and transfer interventions for all residents requiring transfer assistance to verify that transfer requirements accurately reflected each resident's current needs. Any discrepancies identified during the review were corrected immediately.3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.The Director of Nursing and Staff Development Coordinator initiated re-education of all licensed nurses, nursing assistants, and other direct care staff on 6/20/2026. Education was completed by 6/22/2026 and included:Following each resident's individualized transfer interventions as outlined in the resident care guide and care plan.Safe transfer techniques and the importance of using the required equipment and level of assistance.Location of resident-specific transfer requirements, in the Matrix electronic medical recordThe expectation that staff review and follow resident-specific transfer interventions before providing transfer assistance.Any employee who had not completed the required education by 6/22/2026 was removed from the work schedule until the education was completed by the Staff Development Coordinator or Director of Nursing.4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustainedOn 6/22/2026, the facility determined that the following monitoring process would be implemented.The Director of Nursing /designee will complete observations of resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	transfers on all shifts to verify that resident-specific transfer interventions are being followed and that appropriate assistance and equipment are being utilized.Five resident transfer observations will be completed weekly for four weeks, then five resident transfer observations monthly for two months. Audit findings will be reviewed by the Director of Nursing, and any identified concerns will be addressed through immediate corrective action and additional education as needed.The results of the audits and corrective actions will be presented to the facility's quarterly Quality Assurance and Performance Improvement (QAPI) Committee meeting. Additional corrective action will be implemented immediately if concerns are identified. The committee will determine whether additional monitoring or interventions are necessary to ensure sustained compliance.The facility's alleged date of compliance is 6/23/2026.The Responsible person is Director of Nursing. The facility's corrective action plan was validated on 07/01/2026 through staff interviews and transfer observations with nurse aides and nursing staff. All observed staff were able to correctly perform safe transfers using the appropriate level of assistance and equipment. Staff demonstrated knowledge of where and how to review residentˆspecific transfer requirements in the resident profile and were able to verbalize the expectation to review these requirements prior to assisting with any transfer. Staff also accurately described and demonstrated proper steps involved in safe transfers.Audit and monitoring tools included verification of each active resident's profile to ensure transfer status was accurate and up to date. Staff who completed the required education signed attestations for the inˆservices delivered on 06/20/2026. Staff reported they had received the required training prior to beginning their next scheduled shift. Newly hired staff after 06/22/2026 received education during orientation regarding reviewing the resident profile prior to transfer and safe transfer practices, which was confirmed through orientation documentation and trainer verification.On 06/25/2026, Resident #1's electronic medical record (EMR) profile was updated to reflect accurate transfer requirements, including oneˆperson assist for bed mobility, twoˆperson assist with transfers using the mechanical lift, and oneˆperson assist for wheelchair mobility. On 07/01/2026, three observations of safe transfers, including a transfer involving Resident #1, were completed. Nurse Aides demonstrated understanding of Resident #1's transfer needs and followed all specified interventions correctly, safely operating the mechanical lift and performing standˆpivot transfers using proper technique. All observed transfers were completed safely without causing harm.The facility was determined to be back in compliance 06/23/26.