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	03/05/2026

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and staff interviews, the facility failed to discard expired medications stored in 1 of 2 medication storerooms (Station 1 Medication Storeroom), store medications in accordance with the manufacturer's instructions in 1 of 2 medication storerooms (Station 1 Medication Storeroom), and date medications as to when they were opened to allow for the determination of the shortened expiration date in 1 of 2 medication storerooms (Station 3 Medication Storeroom).The findings included:1. An observation was conducted on 3/4/26 at 11:15 AM of the Station 1 Medication Storeroom. The observation revealed the following medications were stored in the medication storeroom:a. An unopened box of Allegra D (an over-the-counter antihistamine and decongestant) containing 15 tablets was stored on the shelf of the medication storeroom. The manufacturer's expiration date of November 2025 was printed on the box containing the tablets, indicating this medication was expired.b. An opened box containing six (6) 14 milligram (mg) Nicotine Transdermal System Patches was stored on the shelf of the medication storeroom. The manufacturer's expiration date of January 2026 was printed on both the box and packaging of the individual patches, indicating the patches were expired.c. An unopened plastic case containing a 1 mg glucagon pen (an injectable medication used to treat low blood sugar) dispensed from the pharmacy on 2/11/26 for Resident #43 was observed in the medication storeroom's refrigerator. The temperature of the refrigerator was 40 degrees Fahrenheit at the time of the observation. The manufacturer's storage instructions on the label of the glucagon pen read in part, Store at controlled room temperature 20 to 25 degrees Celsius (68 to 77 degrees Fahrenheit).On 3/4/26 at 11:30 AM, the Station 1 Unit Manager reviewed the medications identified with a concern in the Station 1 Medication Storeroom. When asked, the Unit Manager reported it was her responsibility to check the storeroom to ensure the medications were not expired and stored properly. The Unit Manager was observed as she collected the identified medications for removal from the medication storeroom.An interview was conducted on 3/5/26 at 1:00 PM with the facility's Director of Nursing (DON) in the presence of the Regional Nurse Consultant. During the interview, the medication storage concerns were discussed. When asked, the DON reported that everyone (including the supervisors) was responsible for checking the medication storeroom to ensure all medications were properly stored and within date. The DON also confirmed that glucagon should not be stored in the refrigerator.2. Accompanied by Nurse #1, an observation was conducted on 3/4/26 at 11:35 AM of the Station 3 Medication Storeroom. The observation revealed the following:One (1) opened, multi-dose vial of Tuberculin PPD (Purified Protein Derivative) injectable solution (used for skin testing in the diagnosis of tuberculosis) dispensed from the pharmacy on 1/28/26 was stored in the medication storeroom refrigerator. Neither the vial nor the manufacturer box it was stored in were labeled as to when the vial had been opened to allow for the determination of its shortened expiration date.The manufacturer's storage instructions for a multi-dose vial of Tuberculin PPD (Purified Protein Derivative) injectable solution (used for skin testing in the diagnosis of tuberculosis) indicated that once opened, the product should be discarded after 30 days. When asked, Nurse #1 reported the vial of PPD solution would need to be discarded.An (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview was conducted on 3/5/26 at 1:00 PM with the facility's Director of Nursing (DON) in the presence of the Regional Nurse Consultant. During the interview, the medication storage concerns were discussed. When asked, the DON reported that everyone (including the supervisors) was responsible to check the medication storeroom to ensure all medications were properly stored and within date. The DON also stated she would expect the nurse who opened a medication to date the medication on the label as to when it had been opened.

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with home health, resident, and staff, the facility failed to implement an effective discharge planning process that ensured the resident was referred for home health services prior to discharge to the community to ensure services were not delayed for 1 of 3 residents (Resident #148) reviewed for discharge.The findings included:Resident #148 was most recently readmitted to the facility on [DATE] with diagnoses that included a displaced fracture of the second right metatarsal bone [a break in the second metatarsal (the longest metatarsal or bone in the foot] where the bone fragments are misaligned), cerebral palsy (a brain disorder that permanently affects body movement and muscle coordination), and muscle weakness.A review of Resident 148's Care Plan dated 01/10/2025 revealed no information related to discharge planning.The 5-day Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #148 was cognitively intact. Her Activities of Daily Living abilities were as follows: independent with eating, oral hygiene, and personal hygiene; supervision for toileting and transfers; partial to moderate assistance for bathing, lower body dressing, and footwear; and setup assistance for upper body dressing. Resident #148 was receiving physical therapy and occupational therapy services. Her overall discharge goal was to return to the community and active discharge planning was noted to already be occurring.A review of the Notice of Medicare Non-Coverage (NOMNC) form for Resident #148 revealed her last covered day in the facility was 01/25/2025. The paperwork included instructions on how to appeal the decision and what happened after an appeal. Resident #148 signed the form on 01/23/2025.The Business Office Manager was interviewed on 03/04/2026 at 8:40 AM. She reported she and her two assistants handled the provision of NOMNC forms. She explained that the business office staff spoke with the residents/responsible parties and provided written and verbal information about the last day of Medicare coverage and the appeal process. She indicated that she did not recall working with Resident #148, but reviewed the record and the NOMNC was provided to Resident #148 on 01/23/2025, with the last day of coverage being 01/25/2025. Resident #148 appealed to the discharge and remained in the facility until her appeal was declined, after which she discharged on01/31/2025. The Business Office Manager reported that the resident was responsible for charges from 01/26/2025 through 01/31/2025.A review of Resident #148's orders revealed an order dated 01/28/2025 stating Discharge Home with Home Health: physical therapy, occupational therapy, and case management services.The Occupational Therapy (OT) Discharge summary dated [DATE] for OT services from 01/08/2025 through 01/25/2025 indicated Resident #148 was admitted to the facility on [DATE] with plans to eventually return home. Prior to admission, Resident #148 lived alone in a private two-level home with one step to enter. Resident #148 participated fairly in therapy and demonstrated fair carryover of education; however, Resident #148 exhausted therapy benefits. Resident #148 would require home health occupational therapy.The Physical Therapy (PT) Discharge summary dated [DATE] for PT services from 01/08/2025 through 01/25/2025 revealed Resident #148 independently used a manual wheelchair for mobility and managed wheelchair propulsion independently. Therapists educated Resident #148 on a supportive home setup, including converting the first floor into a temporary living space, but Resident #148 declined these recommendations. Resident #148 exhausted therapy benefits and declined further treatment, and the interdisciplinary team was to coordinate a discharge that included home health physical therapy.A Nurse Practitioner (NP) note (electronically signed on 02/02/2025) documented that on 01/30/2025 the NP certified that Resident #148 was homebound and required health services due to a nondisplaced fracture of the right second metatarsal and cerebral palsy with right-sided weakness. The NP indicated follow-up with podiatry and neurology was arranged and physical therapy for gait training and occupational therapy for assistance with daily activities were ordered. The note indicated a face-to-face encounter (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with Resident #148 was conducted on 01/30/2025, she reviewed required home health documentation, and communicated with the home health agency.A review of progress notes from 01/07/2025 through 01/31/2025 revealed no information related to discharge planning for Resident #148.A progress note dated 01/31/2025 written by Nurse #8 indicated that Resident #148 was discharged from the facility on 01/31/2025 at 4:45PM.A review of the Discharge/Transfer Plan of Care dated 01/31/2025 completed by Previous Social Services #1 revealed Resident #148 discharged from the facility on 01/31/2025 at 2:00 PM. The discharge status was to home, and she was transported by car with a friend. Resident #148 was to be set up with home health services for occupational therapy, physical therapy, and casework management with Home Health prior to discharge.A review of a fax confirmation to Home Health from the facility revealed the referral information had been faxed on 02/01/2025, after Resident #148 was discharged from the facility. There was no evidence of a referral being sent to Home Health for Resident #148 prior to 02/01/2025.Resident #148 was interviewed by phone on 03/03/2026 at 3:16 PM. Resident #148 reported she had received a discharge notification from the facility on 01/25/2025 and appealed the decision but lost the case. She reported that she remained in the facility while the appeal was pending. Resident #148 indicated it was her decision to discharge home when the appeal was lost because she did not want to remain in the facility and accrue additional costs. She stated that the Social Worker at the facility had informed her that home health services would be arranged before she discharged home; however she didn't hear from Home Health until a few days after discharge. She explained that she was receiving home health services now. She indicated she also had friends who came over to help her with her needs at home.Previous Social Services #1 was interviewed on 03/05/2026 at 9:06 AM. She stated that the discharge planning process happened when a resident entered the facility and continued until they were discharged . Prior to discharge, services were supposed to be set up for a safe discharge and at the time of Resident #148's discharge she (Previous Social Services #1) was responsible for discharge planning. Previous Social Services #1 reported that she recalled Resident #148 and stated that it was her impression that Resident #148 was anxious but eager to return home when she was discharged . She was unable to recall specific details about this resident's discharge but reported that resident was supposed to go home with home health services.Home Health Nurse #2 was interviewed by phone on 03/04/2026 at 10:09 AM and 10:30 AM. Home Health Nurse #2 reported that the referral paperwork for Resident #148 included a home health order dated 01/28/2025. She stated that she first received the referral paperwork regarding the resident on 02/01/2025. Home Health Nurse #2 indicated that normally referrals were received prior to the resident's discharge, so they were able to obtain authorization for services. She explained that it typically took 2 days to obtain authorization. Home Health Nurse #2 reported that she first contacted Resident #148 regarding admission to services on 02/01/2025 and the authorization for care was received on 02/03/2025. She stated that on 02/04/2025, she attempted to contact the resident, but no one answered the phone, and she was unable to leave a voicemail. She further stated that on 02/05/2025, she successfully reached Resident #148, who consented to services, and she completed an introduction to services call and services were initiated.The Director of Nursing (DON) was interviewed on 03/05/2026 at 1:25 PM. She reported that she had not been the DON at that time, but she stated that she would have expected Social Services to arrange for required home health services before a resident left the facility, not afterward.The Administrator was interviewed on 03/05/2025 at 11:35 PM. She reported that she had not been the Administrator at the time, but based on her review of the record Resident #148 lost an appeal after being served a NOMNC and discharged quickly at the resident's request to avoid accruing additional care costs. The Administrator stated that it was a Friday (01/31/2025) when Resident #148 was discharged and based on her experience, Home Health services would not start until 02/03/2025 at the earliest. She provided an email showing that a referral had been sent to Home Health on Saturday 02/01/2025 around 8:30 AM.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of urinary catheter (Resident #157) and medications (Resident #64) for 2 of 29 residents whose MDS assessments were reviewed . The findings included: 1. Resident #157 was admitted to the facility on [DATE] with diagnoses which included flaccid neuropathic (underactive) bladder. Review of the physician orders for Resident #157 revealed an order dated 7/6/25 for an indwelling urinary catheter and to provide urinary catheter care every shift. Review of the physician orders, dated 8/13/25, revealed an order for Resident #157 to discontinue use of the indwelling urinary catheter. Review of the physician orders, dated 8/13/25, revealed an order for Resident #157 to use intermittent urinary catheter as needed. Review of Resident #157's July and August 2025 Medication Administration Records (MAR) revealed nurses documented urinary catheter care every shift from 7/6/25 through 8/13/25. The quarterly MDS assessment dated [DATE] revealed Resident #157 was coded as having an indwelling urinary catheter. The quarterly MDS assessment dated [DATE], revealed Resident #157 was coded as having an indwelling urinary catheter. During an interview with MDS Coordinator #2 on 3/5/26 at 8:45 AM, she indicated that she had completed the 11/7/25 and 1/30/26 MDS assessments for Resident #157 and had coded them incorrectly. She explained at the time of the assessments, Resident #157 no longer had an indwelling urinary catheter and was receiving intermittent urinary catheterizations instead. She stated the MDS should have been coded to reflect intermittent catheterization use. During an interview on 3/5/26 at 12:30 PM the Administrator indicated the expectation was for MDS assessments to be coded accurately for each resident. 2. Resident #64 was admitted to the facility on [DATE] with a diagnosis of mood disorder, major depressive disorder and pain. The diagnosis of localized edema was added on 8/29/24. Resident #64's physician orders dated 4/8/25 included: Risperdal (an antipsychotic medication) 1 milligram (mg) one tablet by mouth once daily for mood disorder Duloxetine (an antidepressant medication) 30 mg one capsule by mouth once daily for major depressive disorder Furosemide (a diuretic medication) 20 mg tablet once daily for localized edema (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No orders for opioid (narcotic pain medication) medications were observed. A review of Resident #64's medication administration record (MAR) for December 2025 revealed: Risperdal 1 mg once daily for treatment of mood disorder, Duloxetine 30 mg once daily for treatment of major depressive disorder, and Lasix 20 mg once daily for treatment of localized edema had been received daily as ordered. A review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] completed by MDS Nurse #2 noted Resident #64 was taking medication from the drug classifications of antipsychotic, antidepressant, diuretic, and opioid. The MDS assessment did not include documented indications (identified, documented clinical rationale for administering a medication) for the use of any of these medications. During an interview with MDS Nurse #2 on 3/5/26 at 12:59PM she revealed not including the medication indications for use on Resident #64's MDS assessment dated [DATE] was an oversite. MDS Nurse #2 confirmed Resident #64 had diagnoses related to the use of antipsychotic, antidepressant, and diuretic medications and acknowledged the resident did not receive any opioid medications. MDS Nurse #2 explained that coding Resident #64 as taking an opioid medication was a mistake. The Director of Nursing was interviewed on 5/5/25 at 1:14PM, she stated she expected the MDS assessments to be coded accurately.