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	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources-Cherryville	7615 Dallas Cherryville Highway Cherryville, NC 28021

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37019 Based on record reviews, and interviews with staff, Nurse Practitioner (NP), and Medical Director (MD), the facility failed to protect resident's right to be free of misappropriation of controlled substances for 1 of 4 residents reviewed for misappropriation of resident property (Resident #4). The findings included: The facility's Abuse, Neglect, Exploitation, and Misappropriation policy, last revised on 01/19/23, revealed in part the facility would ensure all residents were free from misappropriation of property. Resident #4 was admitted to the facility on [DATE] with diagnoses which included fractured hip, pain, and malnutrition. Resident #4 was discharged from the facility to the local acute care hospital on 10/04/24. A review of the physician's order dated 09/27/24 revealed Resident #4 had an order to receive 1 tablet of Hydrocodone-Acetaminophen (an opioid that acts on the central nervous system to relieve pain) 10 milligrams (mg)-325 mg by mouth every 8 hours as needed for pain. The initial allegation report dated 10/04/24 revealed the Administrator became aware of the misappropriation of resident's property on 10/04/24 at 6:25 PM when the nurse medication count revealed a card of 6 tablets of Hydrocode-Acetaminophen 10-325 mg were missing. On 10/04/24, an internal investigation was initiated regarding the allegation of misappropriation of property for Resident #4. The investigation report (5-day) dated 10/09/24 revealed the Director of Nursing (DON) was alerted by Nurse #1 on 10/04/24 at 3:45 PM that a card with 6 tablets of Hydrocodone-Acetaminophen 10-325 mg was missing from the cart. An immediate search was conducted for the missing card which was not located in the cart or the medication room. Nurse #1 verified the card had been in the cart on 10/03/24 when she had counted the narcotics for her oncoming shift of 3:00 PM to 11:00 PM but was turned around backwards due to the resident being out at the hospital. Medication Aide (MA) #1 was contacted by the DON on 10/04/24 and verified when she had counted off at 8:00 AM on 10/04/24 with Nurse #2 the card had been in the medication cart turned backwards due to the resident being out at the hospital. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Peak Resources-Cherryville		STREET ADDRESS, CITY, STATE, ZIP CODE 7615 Dallas Cherryville Highway Cherryville, NC 28021	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The investigation report dated 10/09/24 revealed statements had been obtained from MA #1 and Nurse #1 and both submitted to drug testing completed on 10/04/24 which was negative. Nurse #2 who had custody of the keys and the cart on 10/04/24 from 8:00 AM to 3:00 PM was contacted and requested to return to the facility for interview and drug testing which she declined. On 10/05/24 Nurse #2 was contacted again regarding coming in for interview and drug testing and again declined. On 10/05/24 Nurse #2 contacted the facility and called out for her next shift scheduled on 10/08/24 from 7:00 AM to 3:00 PM. Nurse #2 was terminated by the facility for failure to adhere to company policy. Per the facility investigation report dated 10/09/24, all the carts were audited to ensure an accurate count of controlled substances and to ensure there were no other missing medications. All the other carts were accurate and there were no additional issues noted. The diversion was reported to the local police, the Drug Enforcement Administration (DEA), the local Department of Social Services and Nurse #2 was reported to the Board of Nursing. An interview on 11/12/24 at 3:13 PM with Medication Aide (MA) #1 revealed it had been a while since she had worked at the facility. MA #1 stated she was scheduled to work 7:00 AM to 3:00 PM on the assisted living unit; however, when she arrived at the facility on 10/04/24, she was told to go to the skilled unit to hold the keys for the nurse who was running late. She further stated she and Nurse #3 counted the cart and the card of medication for Resident #4 was in the cart and was turned around backwards when they had counted the cart at 7:00 AM on 10/04/24. She indicated she was holding the keys until Nurse #2 got to work. MA #1 further indicated she asked the other nurses if she should go ahead and start the medication pass on the hall and they told her to start so she did. She said a few minutes after 8:00 AM Nurse #2 came in to work and was screaming at her because she had started her medication pass and demanded she give her the keys to the cart and said they did not count the cart when she handed the keys over to Nurse #2 because Nurse #2 told her she was already running behind and needed to get started on her medication pass. MA #1 stated she gave the keys to Nurse #2 and went to the assisted living unit to work as a Nurse Aide (NA) from 8:00 AM to 3:00 PM. She explained that some time after 3:00 PM she was asked to write a statement and consented to a drug panel because there were missing medications from the cart, she had given medications from earlier in the day. MA #1 said she wrote her statement, and her drug panel was negative. She stated she had received education regarding resident abuse, neglect, exploitation and misappropriation and had been educated on notifying her supervising nurse when medications needed to be returned to the pharmacy. MA #1 further stated she had been educated on the proper procedure for counting carts when leaving duty station. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources-Cherryville	7615 Dallas Cherryville Highway Cherryville, NC 28021

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on 11/12/24 at 3:27 PM with Nurse #1 revealed she was scheduled to work on 10/04/24 from 3:00 PM to 11:00 PM and when she came in, she counted off with Nurse #2 and noticed there was a card of 6 tablets of Hydrocodone for Resident #4 missing that had been in the cart on 10/03/24 at 3:00 PM. She asked Nurse #2 where the card was, and Nurse #2 told her she didn't know and said she had to leave to pick up her child. Nurse #1 stated she immediately notified the charge nurse about the missing card, and they began searching the cart and medication room and were unable to find the card of medication. She further stated while searching for the Hydrocodone they found a card of Diazepam belonging to Resident #4 in the medication room in the pharmacy return basket for non-narcotic medications but did not find the Hydrocodone tablets. Nurse #1 indicated the card was never found but was determined to have gone missing while Nurse #2 had the keys to the cart during the hours of 8:00 AM to 3:00 PM. Nurse #1 further indicated she wrote a statement and consented to a drug panel which came back negative. She explained that she had in-service training after the diversion regarding abuse, neglect, exploitation and misappropriation as well as education on printing narcotic sheets from the electronic medical record and checking the printout against what is in the cart and then both nurses sign indicating the count is correct and no pills were tampered with or missing. Additionally, Nurse #1 stated she had been educated on the proper procedure for counting carts when leaving duty station. A telephone interview on 11/12/24 at 3:40 PM with Nurse #2 revealed she had worked on 10/04/24 during the 8:00 AM to 3:00 PM shift. She stated she was no longer working at the facility. Nurse #2 stated she had not worked at the facility in over a month and could not recall anything about a resident's missing medications and said it had been so long ago that she really couldn't recall if she had worked with Resident #4. She further stated she was currently working with the North Carolina Board of Nursing (NCBON) taking courses to reinstate her license but was not currently working as a nurse anywhere. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources-Cherryville	7615 Dallas Cherryville Highway Cherryville, NC 28021

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 11/12/24 at 3:51 PM with the Director of Nursing (DON) revealed during her investigation of the missing medication card that she discovered working with the business office manager (BOM) that residents who went out to the hospital were put into the electronic medical record (EMR) as hospital leave. She stated that way they were taken out of the census, but their medications remained in the count including narcotics. The DON further stated on 10/04/24, sometime during the 8:00 AM to 3:00 PM shift Resident #4's status was changed in the EMR to discharge/return anticipated which took the medications including their narcotics out of the count. She stated the EMR system did not identify who had made the change in the system, but the change had taken Resident #4's narcotic sheet and remaining tablets on her card out of the system and count which she learned from the corporate office was a flaw in their electronic medical record system. The DON indicated once they discovered the census change, they were able to narrow down the timeline to sometime after 8:08 AM and before 3:45 PM which was the time frame that Nurse #2 had custody of the keys and the cart with the missing Hydrocodone card. She further indicated the charge nurse attempted to call Nurse #2 back to the facility for drug panel testing but she declined and said she was currently out with her family at the fair and could not return to the facility. The DON explained the next day they called Nurse #2 to request she come in to fill out a statement and have a drug panel test and she again declined. She said sometime later 10/05/24 Nurse #2 called the facility and called out for her next scheduled shift which was 10/08/24 from 7:00 AM to 3:00 PM so the facility terminated her employment for failure to adhere to company policy. The DON explained they could not confirm Nurse #2 had taken the card of medication because she had not consented to interview, writing a statement or drug panel but said they were able to narrow the time down to 10/04/24 between 8:08 AM and 3:45 PM as the time the medication card disappeared off the cart. She stated they notified the local police, the state, Drug Enforcement Administration (DEA) and the Department of Social Services of the incident. The DON said she notified the pharmacy and obtained pricing from them to reimburse the resident and to report to the DEA. The DON further stated they had also reported Nurse #2 to the North Carolina Board of Nursing (NCBON). She explained they had done in-service education with all staff on abuse, neglect, exploitation, and misappropriation and they had done in-service education with the medication aides and nurses on proper disposition of patients who are discharged to the hospital, proper return of medications including narcotics and printing disposition sheet and completing it with two nurses signatures and proper storing of narcotics for return to pharmacy in red box with numbered seal. According to the DON, since putting these measures in place there had been no further issues with missing narcotic medications. A telephone interview on 11/13/24 at 9:18 AM with the consulting pharmacist revealed he was not in the facility monthly but someone from the pharmacy conducted random audits of the carts and were mainly looking for outdated medications and discontinued medications that had not been removed from the carts monthly. He stated every six months they conducted a Medication Administration Record (MAR) to cart audit to make sure the orders from the physician match the medications on the cart. The consultant pharmacist further stated they check the narcotics to ensure they are not out of date but said they did not do a narcotic cart card check. He indicated they had never found missing narcotic cards on their audit but was aware of an incident at the facility of a resident's missing narcotic medication. A telephone interview on 11/13/24 at 12:20 PM with the Medical Director (MD) revealed he recalled being told about missing narcotic medications but did not recall the details about it. He stated he had not had the opportunity to see Resident #4 since she was only at the facility for 7 days. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER: Peak Resources-Cherryville		STREET ADDRESS, CITY, STATE, ZIP CODE: 7615 Dallas Cherryville Highway Cherryville, NC 28021	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview on 11/13/24 at with the Nurse Practitioner (NP) at 1:49 PM revealed she recalled being told about the missing narcotic medications but did not recall all the details. She stated she was familiar with Resident #4 and said there had been questions on admission about the dosage of her narcotic medication and her anti-anxiety medication and she had worked closely with Resident #4 and with her family member on getting her medication dosage adjusted to what she was taking at home. The NP further stated it was her understanding the resident had not missed any of her narcotic medication and had suffered no ill effects from the missing medications. The facility provided the following corrective action plan with a completion date of 10/07/24. Address how corrective actions will be accomplished for the resident to have been affected by the deficient practice: On 10/04/24 the Director of Nursing and charge nurse were made aware that Resident #4 had a prescription-controlled medication card containing 6 Hydrocodone-Acetaminophen 10-325 mg pills missing from the medication cart on 10/04/24 between 8:08 AM and 3:45 PM. The resident was not adversely affected by the deficient practice. The resident was in the hospital and did not miss any medication administrations. The narcotic count was corrected. The residents remaining controlled substances (Diazepam) were returned to the pharmacy. On 10/05/24 a Root Cause Analysis was completed by the Director of Nursing and Administrator regarding the missing controlled medication for the resident. It was determined through root cause analysis the discharge census was changed in the electronic medical record (EMR) and the process to reconcile controlled medication by removing medication of discharged resident from the medication cart on 10/02/24 was not followed. How will the facility identify other residents having the potential to be affected by the same deficient practice: On 10/04/24 the Director of Nursing or Designee completed a 100% audit of all the medication carts to ensure no other residents prescribed narcotic medications were missing and reconciled the declining inventory count sheet to ensure the count and the card matched and that medications were available and on med carts on 10/04/24. No discrepancies were noted. DON or designee interviewed alert and oriented residents on 10/06/24 to ensure residents were receiving medications whey they were scheduled or when requested when experiencing pain. No issues were noted. The DON or designee assessed non-interviewable residents for signs and symptoms of pain to ensure pain was being managed appropriately. No concerns were identified. The Administrator and DON interviewed staff members related to the missing controlled medication as well. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024
NAME OF PROVIDER OR SUPPLIER Peak Resources-Cherryville		STREET ADDRESS, CITY, STATE, ZIP CODE 7615 Dallas Cherryville Highway Cherryville, NC 28021	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON or designee re-educated all nurses and medication aides on handling-controlled medications to ensure that all controlled medications that are in the medication cart are listed on the controlled substance count and the narcotic reconciliation were correct. The Administrator on 10/05/24 educated the Business Office Manager, DON, Resident Care Coordinator, Staff Development Coordinator and Charge Nurses regarding correct discharge census to be coded for resident who is transferred to the hospital as hospital leave until and unless the controlled substances for the resident are returned to the pharmacy. The DON or designee educated all licensed nurses and medication aides on the process on 10/05/24. The Administrator and DON re-educated staff with validation of understanding on Abuse, Neglect, Exploitation and Misappropriation with emphasis on Misappropriation of Resident's Property and Drug Diversion on 10/05/24. The Director of Nursing or designee to complete quality monitoring on medication carts weekly for 12 weeks to ensure all medications accounted for with count correct with nurses counting and documenting total medications and total count sheets beginning 10/05/24. How will facility monitor its corrective actions to ensure the deficient practice will not recur: On 10/05/24, after the missing controlled medications were identified the facility Administrator conveyed an ADHOC Quality Assurance Performance Improvement meeting to determine the root cause analysis of the deficient practice, put a plan of action in place to include quality improvement monitoring and frequency of monitoring beginning 10/07/24 to ensure all medications accounted for with count correct with nurses and medication aides counting and documenting total cards and total count sheets including the Administrator, Director of Nursing, Social Services, the Business Office Manager, Human Resources Coordinator, Admissions Director, Staff Development Coordinator and Nurse Managers. The results of the quality monitoring will be brought to the Quality Assurance Performance Improvement (QAPI) meeting monthly to ensure ongoing compliance for 3 months. Quality Improvement monitoring schedule will be modified based on findings of monitoring. Date of Compliance: 10/07/24. The facility's corrective action plan with a correction date of 10/07/24 was validated onsite by observations and interviews with the Director of Nursing and nursing staff. (The Administrator was not available for interview). An observation was conducted during a shift transition for a medication cart between 2 nurses on 11/12/24. Nurses started with the printout from the electronic medical record and counted the total number of blister cards that contained controlled medications stored in the double locked compartment in the medication cart and verified the balance on the narcotic count log. The nurses then counted the total number of declining narcotic sheets and verified the balance in the narcotic count log. The nurses then proceeded to inspect and count each blister card of controlled medication to ensure the quantity listing in the declining narcotic count sheets were consistent with the actual pill count. After all counts were completed and without any discrepancies, the on-coming shift nurse and the off-going shift nurse signed the printout and narcotic count log, and the off-going shift nurse passed the medication cart key to the on-coming shift nurse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources-Cherryville	7615 Dallas Cherryville Highway Cherryville, NC 28021

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A random sample of 3 controlled medications were pulled from the medication cart on 700 hall for verification of accuracy. The controlled substance counts were consistent with the records documented in the declining narcotic count sheets. Interviews with nursing staff including medication aides (MA), licensed practical nurses (LPN) and registered nurses (RN) confirmed they had received education related to Misappropriation of Resident's Property and the narcotic process policy. It included the process for shift-to-shift controlled substance count, verification of on-hand controlled medications and returning discontinued medications to the pharmacy. The nurses and medication aides were able to describe the policy and procedures and verbalized understanding of the education. Review of audit records revealed all residents receiving controlled medications were audited by the DON or designee weekly beginning 10/04/24. Then monthly for 8 weeks to ensure the narcotic count was correct on each cart, shift-to-shift count was completed appropriately, and discontinued controlled medications were removed from the medication carts and returned to the pharmacy. The findings were reported to the QAPI committee for suggestions and/or recommendations; the quality improvement monitoring schedule will be modified based on findings of the monitoring. Reporting results will be continued for 3 months. Interview with the Director of Nursing (DON) revealed the facility launched an in-service related to controlled medication process and accountability immediately after the incident to re-educate all the licensed nurses and medication aides. The DON or designee audited the medication carts in-person randomly to ensure all controlled medication counts were conducted appropriately and the declining narcotic count sheets were documented properly. The DON stated the interventions were successful as the facility did not have any similar diversion issues since then. The compliance date of 10/07/24 was validated.