

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345429	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/25/2025
NAME OF PROVIDER OR SUPPLIER Peak Resources - Pinelake		STREET ADDRESS, CITY, STATE, ZIP CODE 801 Pinehurst Avenue Carthage, NC 28327	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and resident, Family Member, Nurse Practitioner (NP), Medical Director, local law enforcement officer, and staff interviews, the facility failed to protect a resident's right to be free from resident-to-resident abuse when a severely cognitively impaired male resident (Resident #86) grabbed a cognitively intact male resident's (Resident #19's) arm as he was coming out of the bathroom. This was for 1 of 3 residents reviewed for resident-to-resident abuse (Resident #19). The findings included: Resident #19 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy, chronic fatigue, bipolar II disorder, and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #19's cognition was intact, he had no behaviors and was independent with using his wheelchair or walker. Resident #19's care plan dated 9/18/2025 indicated the resident had problem areas that included verbal behavioral symptoms directed toward others; and the resident had poor sense of boundaries. Resident #19 had Level II Pre-admission Screening and Resident Review (PASRR) related to bipolar II disorder. Resident #86 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's dementia with other behavioral disturbances, urinary tract infection, and anxiety. Resident #86's care plan dated 8/25/25 indicated the resident had problem areas that included resident had physical behavioral symptoms towards others; resident had behavioral symptoms with Level II PASRR in place for Alzheimer's dementia and anxiety; resident had a memory/recall problem related to dementia; and resident was at risk for adverse consequences related to receiving antipsychotic medication. The interventions included assessing whether the behaviors endangered the resident and/or others and intervene as necessary, avoid over stimulation and provide a calm environment, resident would receive specialized services recommended by PASRR, to administer medication as ordered and change as necessary, and referral to psychiatric services as needed. An admission MDS assessment dated [DATE] indicated that Resident #86's cognition was severely impaired, he had no behaviors noted and was independent with using his wheelchair. An initial allegation report dated 9/8/25 at 8:43 PM completed by the Director of Nursing (DON) indicated there was an allegation of resident-to-resident abuse between Resident #19 and Resident #86 on 9/8/25. The initial report recorded the facility became aware of the incident on 9/8/25 at 7:00 PM. Details of the allegation stated that Resident #86 physically assaulted Resident #19. Resident #19 was exiting the bathroom when Resident #86 was attempting to get in the bathroom. Resident #86 ran into Resident #19 with his wheelchair and then grabbed Resident #19's arm. Resident #19 then hit Resident #86 on his hands trying to get him to let go. The residents were immediately separated by Nurse Aide (NA) #1 and Nurse #1. Resident #86 was moved to another room immediately. Skin assessments were completed on both residents. Resident #19's skin assessment showed some redness to his right shoulder. Resident #86's skin assessment showed no injury at that time. Local law enforcement made aware of the allegation on 9/8/25 at 7:00 PM and came to the facility and interviewed both residents. Resident #86 had no recollection of the events that occurred, and Resident #19 declined to press charges. Both residents were initiated on 15-minute checks for 72 hours. A skin assessment was completed by the DON on 9/8/25 at 7:00 PM for Resident #86. Skin assessment revealed that no new injury was identified. Medical Director and NP were both made aware of the findings. A skin assessment was completed by the DON on 9/8/25 at 8:34 PM for Resident #19. Skin assessment revealed some redness to the right shoulder; Resident #19 had no concern for pain or discomfort. Medical Director and NP were both made aware of the findings. A written statement completed on 9/8/25 by NA #1 indicated that NA #1 observed Resident #86 trying to back over Resident #19. Resident #19 tried to stop Resident #86, then Resident #86 grabbed Resident #19 by the right arm. On 09/25/2025 at 11:10 AM an interview occurred with NA #1. NA #1 reported that she was walking down the hall from the laundry area when she saw Resident #86 grabbing the arm on Resident #19. NA #1 stated that it appeared that Resident #86 was trying to back into Resident #19 with his wheelchair. NA #1 indicated that Resident #86 was in the doorway area and Resident #19 was coming out of the bathroom. NA #1 did not report that Resident #86 said anything. NA #1 recalled when she saw this happening she went down the hallway to get help from Nurse #1. NA #1 reported that she came back with Nurse #1 and Nurse #1 separated the two residents immediately. A written statement completed on 9/8/25 by Nurse #1 revealed on 9/8/25 around 7:00 PM, NA #1 called Nurse #1 down to the room of Resident #86 and Resident #19. Upon entering the room Nurse #1 saw Resident #86 holding Resident #19 by the arm tightly. Resident #19 was hitting Resident #86's hands in</p>		