STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345494	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources - Gastonia	2780 X-Ray Drive Gastonia, NC 28054

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews, the facility failed to assist a resident, who required staff assistance with transfers, out of bed when requested for 1 of 5 sampled residents reviewed for activities of daily living (Resident #8).Findings included:Resident #8 was admitted to the facility on [DATE] with diagnoses that included disease of spinal cord, chronic pain, chronic obstructive pulmonary disease (difficulty breathing), left hand contracture, and history of falling.The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 had intact cognition and impairment on one side of the upper extremity. She required partial/moderate staff assistance with moving from lying to sitting on the side of the bed and chair/bed-to chair transfers and required substantial/maximal staff assistance with sit-to-stand. Resident #8 displayed no behaviors and did not reject care during the MDS assessment look-back period.Review of Resident #8's comprehensive care plans, last reviewed/revised on 06/11/26 revealed the following active care plans:Resident Profile - Standards of Care Required for Resident indicated Resident #8 had impaired vision due to blindness in the right eye and required one-person assist with transfers. Activities of Daily Living (ADL) Functional Status/Rehabilitation Potential indicated Resident #8 needed assistance with ADL. Interventions included for staff to assist Resident #8 with all ADL that she was unable to complete independently.During an observation and interview on 06/14/26 at 3:36 PM, Resident #8 was in her room sitting in her wheelchair watching TV. Resident #8 reported she liked to get up early each day, at the very least by 10:00 AM, and was unable to transfer independently. Resident #8 stated on Saturday 06/13/26, she wasn't assisted out of bed until 2:45 PM and she missed attending BINGO. Resident #8 stated she used her call bell repeatedly and yelled out for staff for assistance and when staff finally arrived to her room, she was told they were running behind. Resident #8 stated it hurt her feelings when she had to repeatedly request for staff to help her get out of bed.During a follow-up interview on 06/17/26 at 1:42 PM, Resident #8 confirmed she started using her call bell after breakfast for assistance with getting up out of bed and told both NA #1 and Nurse #2 that she wanted up to get a shower and attend BINGO that afternoon. Resident #8 stated as it got closer to lunch time, she even screamed at the top of her lungs for someone to come assist. Resident #8 verified she wasn't assisted up out of bed until 2:45 PM.During a phone interview on 06/17/26 at 9:12 AM, Nurse Aide (NA) #2 confirmed she was assigned to provide care to the residents at the bottom of 300 Hall on 06/13/26 during the hours of 7:00 AM to 3:00 PM. NA #2 stated NA #1 was assigned to the top of 300 Hall where Resident #8 resided. She stated NA #1 was new to the hall and was not that familiar with the residents and she (NA #2) did help NA #1 by telling her what the residents needed at the start of the shift. NA #2 stated Resident #8 was a one person assist with a stand/pivot transfer and usually stayed in bed except to attend BINGO and get a shower. NA #2 recalled Resident #8 mentioning she wanted to attend BINGO on 06/13/26. She stated it was around 2:30 PM before Resident #8 was assisted out of bed and she felt NA #1 just got behind. NA #1 stated NA #2 did not ask her for assistance with any of the residents on 06/13/26.During a phone interview on 06/17/26 at 9:29 AM, NA #1 confirmed she was assigned to provide Resident #8's care on 06/13/26 during the hours of 7:00 AM to 3:30 PM. NA #1 stated she was assigned to the resident (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rooms at the top of the hall where Resident #8 resided and it was her first time working with the residents on 300 Hall. NA #1 reported she was usually assigned to 100 Hall where they had three NAs to provide resident care and 300 Hall only had two NAs. NA #1 stated she got behind because she really didn't know the care needs of the residents she was assigned, had two resident showers to provide and was assigned to assist residents in the dining room during lunch. NA #1 recalled she assisted Resident #8 out of bed around 2:30 PM and provided her a shower. NA #1 did not recall Resident #8 mentioning anything about wanting to attend BINGO that afternoon and the only thing Resident #8 had requested was for NA #1 to put Vaseline on her skin after her shower. NA #1 did not recall hearing Resident #8 yelling out for assistance and stated that anytime Resident #8 had used her call bell, she went into the room to let her know that she hadn't forgotten about her and would assist her just as soon as she finished with another resident. NA #1 stated she had asked NA #2 questions about resident care but did not specifically ask her to assist with getting Resident #8 up out of bed. NA #1 stated she did the best she could and made sure all resident care was provided before she left for the day.During a phone interview on 06/17/26 at 9:53 AM, Nurse #2 confirmed she was assigned to provide Resident #8's care on 06/13/26. Nurse #2 could not recall the exact time(s) but stated some time before lunch, Resident #8 did state that she wanted to go to BINGO and voiced concerns that no one had assisted her up out of bed. Nurse #2 stated she explained to Resident #8 that NA #1 got behind due to having several showers to give but NA #1 would assist her out of bed as soon as she could. Nurse #2 could not recall the exact time when Resident #8 was assisted out of bed but thought it was around 2:00 PM when she was given a shower. Nurse #2 confirmed Resident #8 was a one-person assist with a stand/pivot transfer and stated she did not offer to assist Resident #8 because she was finishing up her medication pass.During an interview on 06/17/26 at 10:38 AM, the Nurse Supervisor stated she facilitated the BINGO activity for residents every other Saturday and the NAs helped get residents to the dining room for the activity. The Nurse Supervisor verified BINGO was scheduled for 2:30 PM on Saturday 06/13/26. She stated Resident #8 usually attended BINGO and it had crossed her mind to go check on Resident #8 but didn't because she got sidetracked getting everything together for the activity. The Nurse Supervisor stated no one had mentioned anything to her on 06/13/26 that Resident #8 had not been assisted out of bed and had she known, she would have gone to assist Resident #8 so that she could have attended BINGO.During an interview on 06/17/26 at 2:27 PM, the Director of Nursing (DON) stated Resident #8 never mentioned any concerns to her about staff not assisting her out of bed on 06/13/26 when requested and she missed attending BINGO. The DON stated NA #1 reported that the only concern Resident #8 had mentioned on 06/13/26 was that she wanted NA #1 to put Vaseline on her skin after the shower. The DON was unaware that Nurse #2 knew that Resident #8 requested to get out of bed and stated Nurse #2 should have assisted Resident #8 as requested if NA #1 was unavailable.During an interview on 06/17/26 at 2:58 PM, the Administrator stated normally with any care concern, it was addressed through the facility's grievance process but Resident #8 never mentioned anything to her or other staff regarding not being assisted out of bed when requested on 06/13/26. The Administrator stated she felt it was an isolated incident. She stated if Resident #8 asked for assistance with getting up out of bed, staff should have provided her with assistance when requested.

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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, observation and staff interviews, the facility failed to follow their infection control policy and procedure for Enhanced Barrier Precautions (EBP) when Nurse #1, did not put on a personal protective equipment (PPE) gown prior to urinary catheter care provided to a resident (Resident #7). The deficient practice occurred for 1 of 4 staff members reviewed for infection control (Nurse #1). Findings included: A review of the facility's Infection Prevention and Control Program for EBP last revised on 10/2025 read in part, EBPs were designed to reduce transmission of multidrug resistant organisms (MDRO) by employing targeted gown use during high-contact resident care activities. EBPs in conjunction with standard precautions to expand the use of PPE to donning (put on) a gown during high-contact resident care activities that provide opportunities for transfer of MDRO's to clothing. PPE - wear a gown for the high-contact care activity of a urinary catheter. An observation of Resident #7's urinary catheter care provided by Nurse #1 was conducted on 06/17/26 from 11:09 AM through 11:27 AM. Posted on the entry door to Resident #7's room was a sign that read in part, EBP - staff must wear a gown for the following high-contact resident care activities of a urinary catheter. A PPE storage container placed on Resident #7's room entry door contained protective gowns and was available for use. Nurse #1 entered the room, washed his hands, put on a pair of gloves but did not put on a protective gown. Nurse #1 cleaned the catheter insert site and tubing using a wound cleanser moistened gauze and flushed 30 milliliters of acetic acid into the catheter tubing. Nurse #7 removed and discarded his gloves in the trash then cleaned his hands by using sanitizing wipes. During an interview on 06/17/26 at 11:27 AM, Nurse #1 stated he did not wear a PPE gown when providing catheter care for a resident. When asked about the EBP sign posted on Resident #7's door with instructions staff must wear a gown for care of a urinary catheter, Nurse #1 stated he wore a PPE gown if a resident was placed on contact precautions. Nurse #1 further stated he did not wear a gown for a resident on EBP and he was not aware that a PPE gown should be worn when he provided care for a urinary catheter.During an interview on 06/17/26 at 12:53 PM, the Infection Preventionist stated EBPs were utilized for residents with a urinary catheter. She revealed EBP signs were used as a reminder and provided instructions on what type of PPE was required when staff provided high-contact resident care. She revealed an educational in-service on EBP, and other isolation precautions was recently provided to staff and showed Nurse #1 signed the attendance sheet. She revealed the in-service included review of the EBP sign and the instructions and stated Nurse #1 was expected to wear a protective gown when he provided care for a resident's urinary catheter.During an interview on 06/17/26 at 1:12 PM, the Director of Nursing (DON) stated she expected Nurse #1 followed EBPs and wore a gown when he provided catheter care for a resident.An interview was conducted on 06/17/26 at 2:18 PM with the Administrator. The Administrator stated she expected Nurse #1 followed the directions for EBPs and wore a gown when he provided catheter care for Resident #7.