

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345537	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/19/2024
NAME OF PROVIDER OR SUPPLIER  Peak Resources-Wilmington, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE  2305 Silver Stream Lane Wilmington, NC 28401	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32968</p> <p>Based on record review, and staff and Nurse Practitioner interviews the facility failed to assess Resident #4 before transferring her back to bed after she was found on the floor for 1 of 2 residents reviewed for falls.</p> <p>The findings included:</p> <p>Resident #4 was admitted to the facility on [DATE].</p> <p>Resident #4's diagnoses included Alzheimer's disease, anxiety, failure to thrive, and cerebrovascular disease.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] revealed that Resident #4 had severe cognitive impairment and required one-person supervision with transfers. There were behaviors and rejection of care noted during the assessment reference period. There was also a history of falls since admission to the facility. The MDS also revealed that Resident #4 had a prognosis of less than 6-months to live and received Hospice care.</p> <p>Resident #4's Medication Administration Record dated 04/2024 revealed the resident was only receiving one medication, Tylenol 500-milligrams three times a day.</p> <p>Review of an initial allegation report dated 04/17/24 at 1:20 PM read, staff reported Resident #4 was observed in bed with a hematoma over right eye, an injury of unknown origin. The resident was not interviewable. The facility staff-initiated skin checks and interviews for residents on the same wing. Staff interviews were initiated. The resident appeared at baseline currently and will be monitored for any negative outcomes. The initial allegation report was completed by Former Administrator #1.</p> <p>A handwritten statement from NA #2 read in part, On 04/17/2024 at 6:30 AM., I found resident #4 on the floor on her mat. She didn't seem hurt, but I placed her up and placed her back on the bed. I changed her and put the bed at the lowest position. The statement was signed by NA #2.</p> <p>(continued on next page)</p>

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A phone interview was conducted on 09/17/24 at 9:57 AM with Nurse Aide (NA) #2. NA #2 confirmed that she was working the night 11:00 PM to 7:00 AM shift on 04/16/24. She stated she was walking past Resident #4's room and found her lying flat on the floor on her fall mat. NA #2 stated she was exhausted that night, and normally would have requested assistance from the nurse but instead she lowered resident's bed and put the resident back in bed. NA #2 stated the resident did not appear to be injured or in any pain. NA #2 stated she should have gone to get the nurse to assess the resident before putting her back to bed and was fired for it.</p> <p>An interview was conducted on 09/17/24 at 1:30 PM with Nurse #1. He confirmed that he was working the day shift on 04/17/24. He stated NA #3 approached him about something. It was reported to him that Resident #4 had a hematoma above her eye, and that NA #2 got her back into the bed without being assessed. Nurse #1 stated that it was not reported to him that Resident #4 had fallen until after NA #2 had transferred her back to bed. He stated when he found out he did go and fully assess Resident #4 for injuries, completed neuro-check, and range of motion but could not identify any other injuries sustained from the fall, except for the hematoma above the resident's eye. After the assessment, Nurse #1 stated he notified the Medical Director (MD)/Physician Assistant (PA), Administrator, Director of Nursing (DON), and resident's Responsible Party (RP).</p> <p>A handwritten statement from NA #3 read in part, I entered Resident #4's room to perform patient care, and noticed a knot on patient's forehead. I notified my nurse and nurse manager. The statement was signed by NA #3.</p> <p>An interview was conducted on 09/18/24 at 9:53 AM with NA #3. NA #3 confirmed that she was working the 7:00 to 3:00 PM day shift on 04/17/24. NA #3 stated she recalled that while making her morning rounds of her residents on the 200-hall, she observed Resident #4 lying in bed with a goose-egg hematoma over her left eye. She said she reported it to Nurse #1 who came, assessed the resident, and notified the Physician Assistant (PA) to also assess, which she did. NA #3 stated the resident did not appear in pain and ate well that morning. NA #3 stated the resident was a one-person assist with transfers, and could pivot and transfer with one NA. NA #3 stated during morning report, before making her rounds NA #2 never mentioned Resident #4 had a fall or injury.</p> <p>An interview was conducted on 09/18/24 at 9:50 AM with the Director of Nursing (DON) and the Corporate Consultant. The DON stated when a resident had a fall they have to be assessed by a nurse before being moved. The NAs should never get anyone up including Resident #4 without an assessment from the nurse. Once the nurse assessed the resident and deemed it safe to move the resident then the resident can be assisted back to bed or chair. They both stated that any resident that had a fall should be assessed by a nurse for injury before being moved.</p> <p>An interview was conducted on 09/18/24 at 12:45 PM with the Physician Assistant (PA). She stated that any resident that had a fall should be assessed by a nurse for injury before being moved.</p> <p>An interview was conducted on 09/19/24 at 1:15 PM with the Administrator. She stated that any resident that had a fall should be assessed by a nurse for injury before being moved.</p>		