STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. Building B. Wing	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources - Shelby	1101 North Morgan Street Shelby, NC 28150

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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 0550 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on observation, record review, resident, and staff interviews the facility failed to provide incontinence care for 1 of 3 residents sampled for incontinence (Resident #2). The resident expressed feelings of being upset. The findings included: 1. Resident #2 was admitted to the facility on [DATE] with diagnosis that included renal insufficiency and Diabetes Mellitus. Review of Resident #2's quarterly Minimum Data Set (MDS) dated [DATE] revealed she was cognitively intact and required extensive assistance of two staff members for bed mobility and transfers. She was coded as being dependent on one staff member for assistance with toileting. Resident #2 was coded as being always incontinent of bladder and frequently incontinent of bowel. Review of Resident #2's care plan dated 12/12/19 and updated on 02/12/21 revealed a focus area for urinary incontinence. The care plan stated Resident #2 was incontinent of bowel and bladder and required fluid restrictions due to congestive heart failure and was at risk for urinary tract infections. Interventions included providing assistance to the bathroom, monitoring of fluid intake and frequent incontinence rounding. On 06/22/21 at 1:45 PM an interview was conducted with Resident #2. During the interview she stated she had been waiting 30-45 minutes for incontinence care because she had urinated and had a bowel movement on herself. She stated the incontinence had soaked through her brief onto her denim pants and she was upset. The interview revealed she had turned on her call light and Nurse #3 came into the room to answer her call light. She stated she told Nurse #3 that she needed to be changed but the nurse did not give her time to explain the severity of her incontinence before leaving the room. The interview revealed Nurse #3 stated to her, I'll let them know. During the interview with Resident #2, Patient Care Aide (PCA) #1 entered the room and asked the resident if she still needed to use the restroom because NA #2 was giving another resident a shower. Resident #2 told the PCA that she had a soiled brief and needed to be changed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 06/22/21 at 1:58 PM an observation was conducted of Nurse Aide #2 providing incontinence care for Resident #2. He stated he was working on another hall however NA #3 who was responsible for the hall was giving a resident a shower and had asked him to keep an eye on her hall. When NA #2 assisted Resident #2 to stand from her wheelchair her incontinence had soaked through her brief onto her pants requiring a complete change of her undergarments. NA #2 stated to Resident #2, you had a mess. NA #2 cleaned the resident, providing a new brief and new pair of pants prior to assisting her back in her wheelchair and taking her to a facility activity. On 06/22/21 at 2:18 PM an interview was conducted with Nurse #3. She stated she was responsible for Resident #2's hall along with the isolation hall. The interview revealed NA #3 was assigned to the resident however was giving another resident a shower. She stated NA #4 was the second NA on the hall and she hadn't told her that she went on break. The interview revealed she saw Resident #2's call light on and went into the room to see what she needed. Resident #2 stated to her that she needed incontinence care and she told her she would tell the NAs. Nurse #3 stated she never had the chance to tell the NAs on the hall because she was called to another resident's room for a crisis situation requiring her attention. She stated when she came out of the other residents room Resident #2's light was off, and she thought the resident had already been assisted with incontinence care. On 06/22/21 at 2:28 PM an interview was conducted with PCA #1. She stated she was the only PCA hired in the building and was responsible for changing beds, passing meal trays and assisting residents with activities. The interview revealed she could not assist residents to the restroom. She stated she had answered Resident #2's light when it was originally on but knew NA #3 was giving another resident a shower and forgot to tell her Resident #2 needed assistance with incontinence care. On 06/22/21 at 2:42 PM an interview was conducted with NA #3. She stated she was assigned to Resident #2 on 06/22/21. The interview revealed nobody had told her Resident #2 needed to go to the restroom or incontinence care. She stated the last time she had provided incontinence care to Resident #2 was prior to the lunch meal at 12:00 PM. On 06/22/21 at 2:54 PM an interview was conducted with NA #4. During the interview she stated she was working on the hall with NA #3. She stated she was on break while NA #3 was in the shower room with another resident and was off of the hall for approximately 12 minutes. The interview revealed she thought she had told Nurse #3 she was going on her break however couldn't remember for sure. On 06/22/21 at 3:07 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated the NAs working on the hall were supposed to tell the Nurse if they go on break and report to the other NA on the hall to ensure someone is covering the hall. She stated she expected for someone to be on the hall at all times tending to the resident's care needs. On 06/22/21 at 3:25 PM an interview was conducted with the Administrator. During the interview she stated someone should be on the hall at all times monitoring and attending to the resident care needs. She stated she was going to write a concern form regarding the incident and investigate it.

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F 0600 Level of Harm - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on resident interview, staff interview and record review the facility neglected to provide incontinent care for 1 of 3 sampled residents (Resident #1) who required extensive assistance and who had requested incontinent care because he had soiled himself. Resident #1 stated he was embarrassed and angry after he had asked to be changed and was told the staff member did not have time resulting in him attempting to clean himself and experiencing a fall. The findings included: Resident #1 was admitted into the facility on [DATE] with diagnosis of renal insufficiency. Review of Resident #1's admission Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact and required extensive assistance of two staff members for transfers. Resident #1 required extensive assistance of one staff member for dressing, toilet use and personal hygiene. The assessment revealed he was incontinent of bowel and bladder. Resident #1's care plan dated 5/28/21 revealed a focus area for Activities of daily living (ADL). The focus area revealed the resident required assistance with ADL care due to limited mobility and incontinence. The goal was for the residents needs to be anticipated and met by staff as evidenced by a clean, neat appearance with no odors. Interventions included assist with transfers, provide assistance with toileting and incontinence care. Review of an incident report dated 06/04/21 at 6:20 AM written by Nurse #2 revealed Resident #1 was observed on the floor. The resident stated he lost his balance leaning forward and slid onto the floor. No apparent injury was reported. The causative factor was described as being generalized weakness; poor core strength related to overall resident decline. The incident report revealed Resident #1 lacked the ability to sustain anatomical alignment Review of Resident #1's medical record revealed neurological check was initiated on 06/04/21 at 6:47 AM. The note revealed Resident #1 was observed on the floor with no complaints voiced from the resident. Resident #1 was released to the transportation company in stable condition for transport to dialysis following his fall. Review of Resident #1's physician orders dated 06/04/21 revealed an order to collect a clostridium difficile colitis specimen (a test to determine if there is inflammation of the colon caused by the bacteria clostridium difficile). The results from Resident #1's stool specimen revealed he had clostridium difficile organisms present in his bowel, but the toxin was not detected. The results stated it could be due to colonization, the resident may be a carrier, or the level of toxin was below the level of detection. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview conducted with Resident #1 on 06/22/21 at 9:26 AM revealed on 06/04/21 Nurse Aide (NA) #1 was assisting him to get ready for dialysis when he began to experience diarrhea. He stated NA#1 assisted him to put his clothing on when he had a bowel movement on himself. He asked NA#1 to change his brief and clothing however she stated to him that she didn't have time to change him. He then told her he could't go to dialysis with feces on himself and to bring him supplies and he would try to clean himself up. The NA left the room to go get two wash cloths- one wet and one dry which she handed to the resident, shut the door and left the room. He stated he was attempting to get the wash cloths from the bedside table when he leaned forward and fell on to his right side hitting his hip onto the floor and the right side of his head. The interview revealed he was sore and experienced pain but had no broken bones. He immediately began to yell for help from the staff and stated it was approximately 5 minutes before NA#1 and Nurse #1 entered the room. The interview revealed his call light was on the floor behind him and he couldn't reach it. He stated at [AGE] years old he felt embarrassed laying in bowel movement on the floor and being unable to care for himself. He also said he was angry at NA#1 for making him feel as if she didn't have time to help him or that the other residents were more important. On 06/22/21 at 9:56 AM an interview was conducted with Resident #1's Power of Attorney (POA). She stated the facility had contacted her on 06/04/21 regarding Resident #1's fall around 6:25 AM. The interview revealed she was confused because she knew the resident could not ambulate independently nor provide activities of daily living (ADL) care independently. The nurse on duty told her he was being prepared for dialysis when he had a bowel movement on himself and the NA told him she didn't have time to change him. When the resident attempted to clean himself, he experienced the fall due to loss of balance. She stated she immediately hung up with the nurse who notified her and called Resident #1 who stated he was still sitting in bowel movement and needed to be changed. She then stated she called the nurse back and asked her to go to his room and change him before he went to dialysis. She stated she could not remember the name of the nurse whom she had spoken with. An interview conducted with NA #1 on 06/22/21 at 11:33 PM revealed she was working with Resident #1 during the third shift assignment on 06/04/21. She stated that morning she was getting the resident ready for dialysis and he was experiencing loose stools. She stated, he was on his call light and I had to change him almost 8 times that night. The interview revealed she felt Resident #1 was constantly hitting his call light in need of assistance that morning. She stated, I got frustrated with him when he said he was having another bowel movement. The interview revealed Resident #1 was dressed in his wheelchair for dialysis when he told NA #1, he had experienced a bowel movement and needed to be changed. She stated she told him that she didn ' t have time to change him again because he had to go to dialysis. The interview revealed NA #1 asked Resident #1 if he could clean himself if she set him up with a washcloth. She stated she gave Resident #1 a washcloth to clean himself with, left the room and shut the door behind her returning to her other assigned hall (Hall A) to assist other residents getting up. She stated when she was finished and returned to the hall around ten minutes later, she noticed his call light was not on and she heard Resident #1 yelling for help. When NA #1 entered Resident #1's room she observed him laying on his side in the floor in the middle of his room. She stated he was complaining of pain on his bottom and was laying in stool. NA #1 then left the room to get Nurse #1 to come assist her in getting him back to bed and cleaned up. She stated Nurse #1 no longer worked in the facility. On 06/22/21 and 06/23/21 interviews were attempted with Nurse #1. Voicemails were left for Nurse #1 with no return phone call. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	An interview conducted with Nurse #2 on 06/22/21 at 11:56 PM revealed she was working during third shift on 06/04/21 as the supervising nurse. She stated Nurse #1 had came up the hall and told her Resident #1 experienced a fall and asked for help completing an incident report. Nurse #2 stated she asked Nurse #1 how Resident #1 a fall and she had stated that the resident was cleaning himself up when he fell forward. Nurse #2 stated she knew Resident #1 was unable to complete ADL care independently, so she went immediately to his room to ask him why he was cleaning himself up. Resident #1 told Nurse #2 that he was sitting in his wheelchair when he had a bowel movement on himself and asked NA #1 to change him. He stated NA #1 told him she didn't have time to change him and he was trying to clean himself up before he went to dialysis because he didn't want to sit in feces. Nurse#2 stated she went out of his room and found NA #1 and to ask her to check him again to ensure he was clean prior to leaving and told her dialysis would not change him or clean him up. The interview revealed the dialysis transporter was in the facility at that time and she told him to wait 10 minutes so NA #1 could clean the resident prior to leaving the facility. Nurse #2 stated she told the Director of Nursing about the incident and he told her he didn't need her statement and if he did, he would call her. The interview revealed the DON had never contacted Nurse #2 regarding the incident. She stated Resident #1 seemed very upset and embarrassed over the situation. On 06/22/21 at 11:18 AM an interview was conducted with the former Director of Nursing (DON). During the interview he stated he came into the facility on [DATE] to find the incident report in his box for Resident #1's fall. He stated he didn't recall talking to NA #1 that morning despite being in the building at 6:00 AM. The DON stated he went into the room to speak with Resident #1 and called his Responsible Party to inform her of the fall that had occurred. He stated he reviewed Resident #1's chart and saw how the nurses and NAs were transferring the resident to see if he was capable of being set up on his own to clean himself. The interview revealed Resident #1 was always laying flat in the bed and had lost his core strength and did not have the ability to sit up on his own. He stated Resident #1 was not appropriate to be alone by himself and required a one-person assistance with ADL. The DON stated he verbally spoke to the staff working with Resident #1 on 06/04/21 and informed them to not leave the resident alone and that he needed a one staff member assistance. He stated, the resident looked young, so it made staff feel like he was able to complete task on his own. The interview revealed he had verbally conducted an in-service on the incident and didn't remember having written documentation of an in-service.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40476 Based on record review, resident, power of attorney and staff interviews the facility failed to implement their abuse and neglect policy in the area of reporting for resident neglect for 1 of 3 resident reviewed (Resident #1). The findings included: Review of Resident #1's admission Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact for decision making. He was coded as requiring extensive assistance of two staff members for transfers. Resident #1 required extensive assistance of one staff member for dressing, toilet use and personal hygiene. The assessment revealed he was incontinent of bowel and bladder. An interview conducted with Resident #1 on 06/22/21 at 9:26 AM revealed on 06/04/21 NA#1 was assisting him to get ready for dialysis when he began to experience diarrhea. He stated NA#1 assisted him to put his clothing on when he had a bowel movement on himself. He asked NA#1 to change his brief and clothing however she stated to him that she didn't have time to change him. He then told her he couldn't go to dialysis with feces on himself and to bring him supplies and he would try to clean himself up. The NA left the room to go get two washcloths - one wet and one dry which she handed to the resident, shut the door, and left the room. He stated he was attempting to get the washcloths from the bedside table when he leaned forward and fell on to his right side hitting his hip onto the floor and the right side of his head. He immediately began to yell for help from the staff and stated it was approximately 5 minutes before NA#1 and Nurse #1 entered the room. The interview revealed his call light was on the floor behind him and he couldn't reach it. An interview conducted with NA #1 on 06/22/21 at 11:33 PM revealed she was working with Resident #1 during the third shift assignment on 06/04/21. She stated that morning she was getting the resident ready for dialysis and he was experiencing loose stools. She stated, he was on his call light and I had to change him almost 8 times that night. The interview revealed she felt Resident #1 was constantly hitting his call light in need of assistance that morning. She stated, I got frustrated with him when he said he was having another bowel movement. The interview revealed Resident #1 was dressed in his wheelchair for dialysis when he told NA #1, he had experienced a bowel movement and needed to be changed. She stated she told him that she didn't have time to change him again because he had to go to dialysis. The interview revealed NA #1 asked Resident #1 if he could clean himself if she set him up with a washcloth. She stated she gave Resident #1 a washcloth to clean himself with, left the room and shut the door behind her returning to her other assigned hall (Hall A) to assist other residents getting up. She stated when she was finished and returned to the hall around ten minutes later, she noticed his call light was not on and she heard Resident #1 yelling for help. When NA #1 entered Resident #1's room she observed him lying on his side in the floor in the middle of his room. She stated he was complaining of pain on his bottom and was laying in stool. NA #1 then left the room to get Nurse #1 to come assist her in getting him back to bed and cleaned up. She stated Nurse #1 no longer worked in the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted with Nurse #2 on 06/22/21 at 11:56 PM revealed she was working during third shift on 06/04/21 as the supervising nurse. She stated Nurse #1 had came up the hall and told her Resident #1 experienced a fall and asked for help completing an incident report. Nurse #2 stated she asked Nurse #1 how Resident #1 fell and she had stated that the resident was cleaning himself up when he fell forward. Nurse #2 stated she knew Resident #1 was unable to complete ADL care independently, so she went immediately to his room to ask him why he was cleaning himself up. Resident #1 told Nurse #2 that he was sitting in his wheelchair when he had a bowel movement on himself and asked NA #1 to change him. He stated NA #1 told him she didn ' t have time to change him and he was trying to clean himself up before he went to dialysis because he didn't want to sit in feces. Nurse#2 stated she went out of his room and found NA #1 and to ask her to check him again to ensure he was clean prior to leaving and told her dialysis would not change him or clean him up. The interview revealed the dialysis transporter was in the facility at that time and she told him to wait 10 minutes so NA #1 could clean the resident prior to leaving the facility. Nurse #2 stated she told the Director of Nursing about the incident however he told her he didn't need her statement and if he did, he would call her. The interview revealed the DON had never contacted Nurse #2 regarding the incident. Review of the facility's 24-hour report and 5-day investigation reports revealed no initial 24-hour report, or 5-day investigation was filed regarding the incident with Resident #1 on 06/04/21. On 06/22/21 at 11:18 AM an interview was conducted with the former Director of Nursing (DON). During the interview he stated he came into the facility on [DATE] to find the incident report in his box for Resident #1's fall. He stated he reviewed Resident #1's chart and saw how the nurses and NAs were transferring the resident to see if he was capable of being set up on his own to clean himself. The interview revealed resident #1 was always lying flat in the bed and had lost his core strength and did not have the ability to sit up on his own. He stated Resident #1 was not appropriate to be alone by himself and required a one-person assistance with ADL. The DON stated he verbally spoke to the staff working with Resident #1 on 06/04/21 and informed them to not leave the resident alone and that he needed a one staff member assistance. He stated, the resident looked young, so it made staff feel like he was able to complete task on his own. The DON stated he did not complete a 24-hour report or conduct a 5-day investigation regarding the incident because he felt that it wasn't necessary.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record review, resident and staff interviews, the facility failed to use a total mechanical lift to transfer 1 of 3 residents (Resident #4) reviewed for accidents. Nurse Aide #5 used an assistive lift (sit to stand lift) and transferred Resident #4 without 2-staff assistance, resulting in a fall without injury. The findings included: Resident #4 was admitted to the facility on [DATE] with diagnoses that included ataxic cerebral palsy, repeated falls and abnormalities of gait and mobility. The Quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #4 was cognitively intact and required extensive physical assistance with most activities of daily living including transfer in which he required 2-staff assistance. Resident #4's balance when moving from seated to standing position and during surface-to-surface transfer was not steady and he was only able to stabilize with staff assistance. The MDS further indicated that Resident #4 had impairment to both lower extremities. Resident #4's care plan last reviewed on 5/20/21 for standards of care required for Resident #4 revealed an intervention started on 1/8/21 for mechanical lift transfers: Total lift x 2 assist for transfers. A review of an incident report entitled, Summary of Investigation, dated 6/14/21 at 10:50 AM revealed Resident #4 was observed on floor. Nurse Aide (NA)#5 was present and indicated resident fell while being transferred with a sit to stand lift. The causative factor listed for the fall was that Resident #4 requested an alternate lift which was the sit to stand lift. The sit to stand lift was taken out of service for maintenance to check. Resident #4 complained of mid-back pain but denied hitting his head. The Director of Nursing (DON) discussed with Resident #4 to continue to use the total lift for transfers for his and staff's optimal safety. An interview was conducted with Resident #4 on 6/22/21 at 11:10 AM. Resident #4 remembered having fallen on 6/14/21 morning before lunch time. Resident #4 stated after he got assisted with dressing in bed and was ready to be transferred out of bed and into his wheelchair, NA #5 used the sit to stand lift to transfer him into his wheelchair. Resident #4 could not remember if he had requested for NA #5 to use the sit to stand lift instead of the total lift but he added that he probably did and he did not want to get NA #5 in trouble. Resident #4 stated the sling on the sit to stand lift came loose and he slipped off the sling and fell to the floor. He remembered his whole back touched the floor when he fell , and he had some shoulder pain after the fall. Resident #4 stated he did not hit his head on the floor. Resident #4 confirmed that NA #5 was by herself when she transferred him using a sit to stand lift. The staff members got Resident #4 off the floor using a total lift and put him back into his wheelchair where he was assessed by Nurse #4. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with Nurse Aide (NA) #5 on 6/22/21 at 3:55 PM revealed that on 6/14/21, NA #5 had used the total lift to get Resident #4 off the bed and into a shower chair and then used the total lift again to transfer Resident #4 off the shower chair into his bed to help him get dressed. After getting Resident #4 dressed and ready to sit back in his wheelchair, Resident #4 insisted for NA #5 to use the sit to stand lift instead of the total lift. NA #5 stated she knew she was not supposed to use a sit to stand lift on Resident #4, but he begged her to use it instead of a total lift. NA #5 stated she placed the sling behind his back while hooking both sides to the sit to stand lift. She remembered locking the buckle that secured the sling on Resident #4. NA #5 also stated that she secured the leg straps around Resident #4' legs. NA #5 stated when she was getting ready to lower Resident #4 into his wheelchair, she suddenly heard a pop and then she saw Resident #4 fall to the floor. NA #5 was not sure what happened or what caused the pop but noticed that the sling was still on the sit to stand lift while Resident #4 had come off it and was on the floor. NA #5 further stated Resident #4 might have slid through the sling or the buckle on the sling might have come loose. NA #5 alerted Nurse #4 who helped get Resident #4 off the floor using a total lift. NA #5 confirmed she transferred Resident #4 using the sit to stand lift by herself and she did not know why she did. NA #5 knew there was supposed to be another person present whenever she had to transfer Resident #4 due to his increased risk for falls. NA #5 reported this was not the first time Resident #4 had requested to be transferred using the sit to stand lift instead of the total lift. An interview with Nurse #4 on 6/22/21 at 10:21 AM revealed NA #5 came to her on 6/14/21 and notified her that Resident #4 had fallen. When Nurse #4 went to Resident #4's room, she observed him lying on the floor on his back. NA #5 told Nurse #4 that she had used the sit to stand lift to transfer Resident #4 instead of a total lift. Nurse #4 assisted NA #5 in getting Resident #4 back into his wheelchair using a total lift. Nurse #4 assessed Resident #4 for possible injuries and checked his vital signs which were normal. Resident #4 complained of shoulder pain, so Nurse #4 obtained an order to get an x-ray of his shoulders which turned out negative for any abnormal findings. An interview with the Director of Nursing (DON) on 6/22/21 at 11:30 AM revealed she found out about Resident #4's fall on 6/14/21 when both Resident #4 and NA #5 told her that he fell while he was being transferred using a sit to stand lift. Resident #4 had voiced multiple requests for NA #5 to just use a sit to stand lift instead of a total lift. When NA #5 started to lower Resident #4 into his wheelchair, she heard something pop and then Resident #4 came out of the sling. The DON stated they took the sit to stand lift out of service and had it checked by maintenance who could not find anything wrong with it or the sling that was used on Resident #4. The only thing the DON could figure out was that Resident #4 must have slipped out of the sling during the transfer using the sit to stand lift. An interview with the Rehabilitation Manager (RM) on 6/22/21 at 11:48 AM revealed therapy had recommended for Resident #4 to use a total lift for transfers for safety due to his history of having cerebral palsy. The RM stated Resident #4 used to be able to use a sit to stand lift but he began to have issues with his core strength and was unable to bear at least 75% of his weight which was required in order to be able to use a sit to stand lift. He also remembered an episode when Resident #4 was working with physical therapy in January 2021 when they decided he needed a total lift for transfers. The RM stated he was familiar with Resident #4 and he did not have the shoulder strength to support himself in a sit to stand lift. The RM also stated all transfers using lifts should be performed by two staff members for safety especially with Resident #4. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345229	A. Building B. Wing	06/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Peak Resources - Shelby	1101 North Morgan Street Shelby, NC 28150

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Administrator on 6/22/21 at 3:25 PM revealed she found out that Resident #4 had requested NA #5 to use a different lift when he fell on [DATE]. The Administrator stated NA #5 should not have used a sit to stand lift and should have used a total lift which was on Resident #4's resident profile.