STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	08/25/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CARE & REHABILITATION CENTER	**604 STOKES STREET EAST AHOSKIE, NC 27910**

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F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record reviews the facility failed to accurately code the Minimum Data Set (MDS) for 3 of 4 sampled residents (Residents #36, 39 and 48) reviewed for Pre-Admission Screening and Resident Review (PASRR).	F 278	1. A. R 39 MDS reviewed and modified on 8/25/16. B. R 36 MDS reviewed and modified on 8/25/16. C. R 48 MDS reviewed and modified on 8/25/16.	9/16/16

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

Electronically Signed | 09/06/2016

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F 278	Continued From page 1 Findings included: 1. Resident #39 was admitted to the facility on 2/25/09 with diagnoses that included schizophrenia, paranoid states and depression. Review of the resident ' s chart revealed a PASRR Level II Determination Notification letter, dated 7/8/13, that indicated the resident was a PASRR Level II. The Annual MDS, dated 6/14/16, did not identify Resident #39 with a PASRR Level II. The Social Worker (SW) was interviewed on 8/24/16 at 4:16 PM. She stated she was responsible for making sure all resident had PASRR numbers and keeping a list of all residents with a Level II PASRR. The SW added when she received notification a resident had been given a Level II PASRR, she informed the Director of Nursing, the Administrator and the Business Office Manager. She added the information was not shared with the MDS Coordinator. The SW was unaware who was responsible for completing Section A of the MDS. On review of Resident #39 ' s MDS, she acknowledged Resident #39 had a PASRR Level II and therefore, the MDS had been coded inaccurately. The MDS Coordinator was interviewed on 8/24/16 at 4:36 PM. She stated Section A of the MDS, including PASRR information was completed by the MDS nurses. The MDS nurse stated typically she asked the SW for a list of residents with a PASRR Level II, but had not asked for the list in a while. The MDS nurse acknowledged if Resident	F 278	2. Residents identified with a serious mental illness have the potential to be affected by this deficient practice. MDS' for residents with serious mental illness were reviewed on 8/24/16 and no other discrepancies were identified. 3. a.)MDS coordinators were educated on proper coding by the Regional Nurse Consultant for section A 1500 on 8/24/16 date. RAI manual section A 1500 was reviewed with the MDS coordinators and the Social Service director on 8/24/16. b.)Social service director to notify MDS coordinator for residents admitted with serious mental illness. New admissions will be reviewed in clinical morning meeting to ensure that PASSR is complete and in medical record. MDS coordinator to review PASRR prior to coding section A1500. The MDSC/designee will audit section A1500 for completed MDS weekly x4 weeks and then monthly x 3 months. Any discrepancies in coding will be corrected by the MDSC. 4. Results of these audits will be forwarded to the QAPI committee. The QAPI committee will determine the need for further audits/action plans.	

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#39 had a PASRR Level II, then the annual MDS had been coded inaccurately because she had not had the proper information.

2. Resident # 36 was admitted in 5/1/15 with diagnoses that included depression and schizophrenia.

Review of a 5/1/15 PASRR Level II Determination Notification indicated Resident #36 had a Level II PASRR.

Review of the Annual MDS, dated 2/3/16, failed to code Resident #36 as a resident with a Level II PASRR.

The Social Worker (SW) was interviewed on 8/24/16 at 4:16 PM. She stated she was responsible for making sure all resident had PASRR numbers and keeping a list of all residents with a Level II PASRR. The SW added when she received notification a resident had been given a Level II PASRR, she informed the Director of Nursing, the Administrator and the Business Office Manager. She added the information was not shared with the MDS Coordinator. The SW was unaware who was responsible for completing Section A of the MDS. On review of Resident #36 ' s MDS, she acknowledged Resident #36 had a PASRR Level II and therefore, the MDS had been coded inaccurately.

The MDS Coordinator was interviewed on 8/24/16 at 4:36 PM. She stated Section A of the MDS, including PASRR information was completed by the MDS nurses. The MDS nurse stated typically she asked the SW for a list of residents with a PASRR Level II, but had not asked for the list in a

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while. The MDS nurse acknowledged if Resident #36 had a PASRR Level II, then the annual MDS had been coded inaccurately because she had not had the proper information.

3. Resident #48 was admitted on 9/29/15 with bipolar disease and dementia.

Review of a 5/21/13 PASRR Level II Determination Notification indicated the resident qualified with a Level II PASRR.

The 5/30/16 Annual MDS for Resident #48 indicated she had not been coded as a Level II PASRR.

The Social Worker (SW) was interviewed on 8/24/16 at 4:16 PM. She stated she was responsible for making sure all resident had PASRR numbers and keeping a list of all residents with a Level II PASRR. The SW added when she received notification a resident had been given a Level II PASRR, she informed the Director of Nursing, the Administrator and the Business Office Manager. She added the information was not shared with the MDS Coordinator. The SW was unaware who was responsible for completing Section A of the MDS. On review of Resident #48 ' s MDS, she acknowledged Resident #48 had a PASRR Level II and therefore, the MDS had been coded inaccurately.

The MDS Coordinator was interviewed on 8/24/16 at 4:36 PM. She stated Section A of the MDS, including PASRR information was completed by the MDS nurses. The MDS nurse stated typically she asked the SW for a list of residents with a PASRR Level II, but had not asked for the list in a

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F 278	Continued From page 4 while. The MDS nurse acknowledged if Resident #48 had a PASRR Level II, then the annual MDS had been coded inaccurately because she had not had the proper information.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to care plan fluid restriction for 1 sampled resident (Resident # 113) who was reviewed for hydration. Findings included:	F 279	1. R 113's care plan was reviewed and revised on 8/24/16 date. 2. Residents that have an order for fluid restriction have the potential to be affected by this deficient practice. Care	9/16/16

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F 279	Continued From page 5 Resident #113 was admitted to the facility on 10/28/15 with diagnoses that included ends stage renal disease requiring dialysis. Resident #113's care plan, last reviewed indicated the resident's dialysis was care planned. One of the interventions was no pitcher at bedside. There was no indication given as to why a water pitcher at bedside was not desired. The care plan also addressed a potential for fluid volume imbalance. The care plan did not identify a fluid restriction, measurable goals or interventions related to the fluid restriction. Under the problem addressing the potential for nutritional risk, there were 2 interventions that indicated a fluid restriction per order and no water pitcher in the room. Goals were not directed toward the fluid restriction. The 7/13/16 Quarterly Minimum Data Set (MDS) indicated Resident #113 was cognitively intact and received dialysis. Review of the August 2016 physician's orders included an order for a 1200 cubic centimeter (cc) per day fluid restriction. Per the orders, 120 cc of fluid was to be given with each medication pass and dietary provided 280 cc of fluid on each meal tray. The MDS Coordinator and the MDS nurse were interviewed on 8/24/16 at 4:41 PM. The MDS Coordinator stated decisions as to what to care plan started with the Care Area Assessment and included any additional relevant information. She added typically fluid restriction was care planned. The MDS nurse reviewed the care plan for Resident #113 and acknowledged the resident's fluid restriction had not been identified as a	F 279	plans were reviewed and revised for all residents that have an order for fluid restriction on 8/26/16. 3. Nursing staff to be in serviced by DON/Designee to initiate potential for fluid volume deficit care plans for residents that are admitted with or receive new orders for fluid restrictions by 9/9/16.Residents on fluid restriction will be reviewed daily in the clinical morning meeting for appropriate care planning and documentation. ADON/Designee to complete an audit weekly x4 weeks and then monthly x 3 months on residents that are on a fluid restriction to ensure care plan reviewed and revised. 4. Results of these audits will be forwarded to the QAPI committee. The QAPI committee will determine the need for further audits/action plans.	

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F 279	Continued From page 6 problem with measurable goals and interventions to attain those goals.	F 279		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain 2 of 3 ice machine storage bins in clean and sanitary condition. Findings included: 1. An observation of the ice machine located in the kitchen was made on 8/22/16 at 10:45 AM. The dietary manager (DM) was present during the inspection. A soft ball size cluster of black spots was observed on the right inside wall of the ice machine ' s collection bin. The DM wiped the black spots with a clean white cloth and stated she thought the spots were mold. An interview with the DM was conducted on 8/22/16 at 10:45 AM. The DM stated the ice machine was cleaned once a month by dietary staff. When asked when the ice machine ' s collection bin was most recently cleaned, the DM	F 371	1. No residents were identified to be affected by this deficient practice. 2. Residents that receive ice from the kitchen and unit 300 have the potential to be affected by this deficient practice. Ice Machines in the kitchen and unit 300 were both cleaned on 8/24/16. 3. Maintenance staff educated by the RD and Nurse Consultant regarding cleaning on ice machines on a monthly basis on 8/25/16. Ice machines will be audited weekly x 4 weeks and then monthly for cleanliness by the Director of Maintenance. 4. Results of these audits will be forwarded to the QAPI committee. The QAPI committee will determine the need	9/16/16

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F 371	Continued From page 7 stated she was unsure. An interview with the Administrator (AD) was conducted on 8/25/2016 at 11:03 AM. The AD stated it was his expectation the ice machines be cleaned regularly. 2. An observation of the ice machine located in the dining room on the 300 hall was made on 8/24/2016 at 10:52 AM. The Assistant Director of Nursing (ADON) was present during the inspection. Several scattered black spots were observed on the right inside wall of the ice machine ' s collection bin. The ADON stated she did not know what the black spots were and stated she thought the housekeeping staff was responsible to clean the ice machine ' s collection bin. On 8/24/2016 at 11:02 AM an observation of the ice machine located in the dining room on the 300 hall was made with the facility ' s Maintenance Director (MD) present. Several scattered black spots were observed on the right inside wall of the ice machine ' s collection bin. The MD wiped the black spots off with a clean paper towel. The MD stated he did not think the black spots were mold and stated he was unsure what the black spots were. The MD stated the maintenance department was responsible for the mechanical part of the ice maker, to ensure it was functioning properly. The MD stated the mechanical parts of the 300 hall ice machine had been serviced about six weeks ago. An interview with the Maintenance Assistant (MA) was conducted on 8/25/2016 at 9:08 AM. The MA stated on 8/24/2016 after the MD inspected the ice machine on the 300 hall, he observed black	F 371	for further audits/action plans.	

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spots in the ice machine ' s collection bin. The MA stated he did not know what the black spots were but black spots should not have been on the walls of the ice machine ' s collection bin. The MA stated the maintenance department was responsible for making sure the mechanical parts of the ice machine were clean and working. The MA stated he thought housekeeping was responsible for cleaning the ice machine ' s collection bin.

An interview was conducted with the Housekeeping Manager (HM) on 8/25/2016 at 10:13 AM. The HM stated the housekeeping department was responsible for keeping the outside of the ice maker clean. The HM stated she was unsure who was responsible for cleaning the inside of the 300 hallway ' s ice machine ' s collection bin.

An interview with the Administrator (AD) was conducted on 8/25/2016 at 11:03 AM. The AD stated it was his expectation the ice machines be cleaned regularly.

An interview with the Facility ' s Consultant Registered Dietician (RD) was conducted on 8/25/2016 at 11:05 AM. The Consultant RD stated it should be the facility ' s maintenance staff who was responsible for cleaning the inside of the ice machines monthly and the housekeeping staff was responsible to clean the outside of the ice machines daily.