STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345407	A. BUILDING _____ B. WING _____	03/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSS CREEK HEALTH CARE	1719 SWAN QUARTER ROAD SWANQUARTER, NC 27885

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to complete a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS)following a decline in activities of daily living (ADLs) for 1 (Resident #38) of 3 residents sampled for ADL care. The findings included: Resident #38 was admitted to the facility on 11/18/16 with diagnoses which included hemiparesis, hypertension and renal failure. He was discharged to the hospital on 1/17/17 and readmitted to the facility on 2/1/17. His new diagnosis included pulmonary failure and end stage renal disease which required hemodialysis. A review of the MDS assessments submitted revealed a 30 day scheduled assessment dated 12/16/16, a discharge return not anticipated on 1/17/17 when Resident #38 was discharged to the hospital, an entry tracking record was completed on 2/1/17. The last submitted MDS	F 274	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 274 SS= D Corrective Action for Resident Affected A Significant Change MDS Assessment was completed for Resident # 38 on 3/6/17 by the MDS Coordinator. Corrective Action for Resident Potentially	3/13/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2017

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F 274	Continued From page 1 assessment was a quarterly review dated 2/7/17. A comparison of the 30 day MDS dated 12/16/16 to the quarterly MDS dated 2/7/17 revealed a decline from extensive assistance to totally dependent in the areas of bed mobility, locomotion on and off the unit and personal hygiene. There was no evidence of a significant change assessment. Nursing Assistant (NA) #1 was interviewed on 2/28/17 at 2:11 PM. She stated Resident #38 needed assistance with feeding sometimes like when he returned from hemodialysis. NA #1 said she had to assist him with something every day that she worked. She added that Resident #38 was incontinent all the time now but she remembered he was continent at times before he went to the hospital. During an interview with the Administrator on 3/1/17 3:00 PM she stated the MDS nurse was not available. During an additional interview with the Administrator on 3/1/17 at 3:30 PM she stated when Resident #38 returned from the hospital he had declined in his ability to perform ADLs and was now always incontinent. She stated Resident #38 was worse when he returned from the hospital and a significant change in status assessment should have been completed.	F 274	Affected Hospital Readmission records for the past ninety days were reviewed on 3/7/17 by the MDS Coordinator to determine if any significant change MDS Assessments were indicated. No coding errors were found. Systemic Changes The Interdisciplinary Care Plan Team (IDCPT) will review each readmission, staff reported decline/improvement, election of hospice, or quarterly/annual MDS review at the next scheduled weekly meeting to determine if a significant change related to a decline or improvement in the resident's status that: 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions. 2) Impacts more than one area of the resident's health status. 3) Requires interdisciplinary review and/or revision of the care plan has occurred. The MDS Coordinator will complete the Significant Change MDS as indicated by the IDCPT results. Quality Assurance The Administrator or Designee will monitor this issue during the Daily, Monday through Friday, Clinical Quality Assurance Meeting. The monitoring will include verifying that readmissions are reviewed to determine if the criteria for a significant change assessment is met. Results will be reported weekly to the QOL/QA committee and corrective action	

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F 274	Continued From page 2	F 274	initiated as appropriate. This will be done for three months and extended as needed until 100% compliance is achieved. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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	F 278		3/13/17

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F 278	Continued From page 3 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 2 of 2 residents (Resident #5 and Resident #3) reviewed for Preadmission Screening and Resident Review (a process used to determine if nursing facility placement was appropriate to meet the needs of an individual), and 1 of 1 resident (Resident #5) reviewed for hospice care. Findings included: 1. Resident #5 was originally admitted to the facility on 7/15/16 and readmitted on 1/17/17. A care plan initiated 1/20/2017 revealed Resident #5 had a Level II PASRR related to severe mental illness. A letter from the Division of Medical Assistance dated 10/17/16 was reviewed and revealed Resident #5 was determined to be a PASRR Level II. A review of the latest significant change MDS dated 2/1/17 revealed Resident #5 was moderately cognitively impaired and had active diagnoses which included depression, bipolar disease, schizophrenia, and palliative care. Section A, the resident identification section of the MDS, was coded "No" for the Preadmission Screening and Resident Review (PASRR) assessment, and Section "O", the Special Treatment, Procedure, Programs section was coded "No" related to hospice care.	F 278	F 278 SS= D Corrective Action for Resident Affected The Minimum Data Set (MDS) was corrected for Resident #5 and Resident #3 to reflect a Level II Preadmission Screening and Resident Review (PASARR) on 03/06/17 by the MDS Coordinator. The Minimum Data Set (MDS) was corrected for Resident #5 to reflect yes for Hospice Care on 03/06/17 by the MDS Coordinator Corrective Action for Resident Potentially Affected All Resident records were reviewed to determine if PASARR coding and Hospice coding was accurate on 3/6/17 by the MDS Coordinator. No coding errors were found. The PASARR form for residents with a level II determination were scanned into the electronic medical record on 3/13/17 by the Business Office Manager Systemic Changes The Social Services Coordinator or designee will scan PASARR	

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F 278	Continued From page 4 2. Resident #3 was admitted to the facility 3/6/13. A PASRR determination letter dated 4/3/2008 revealed Resident #3 was provided a PASRR number which reflected no expiration date or need to be recertified. A review of the most recent annual MDS dated 8/31/16 revealed Resident #3 was cognitively intact and had active diagnoses which included schizophrenia. Section A, the resident identification section of the MDS, was coded "No" for the PASRR assessment. A care plan last updated 1/20/2017 revealed Resident #3 had a Level II PASRR care plan related to severe mental illness. An interview was conducted on 2/28/17 at 3:00 PM with the Business Office Manager. She stated, "PASRR Level II arrived with the resident. If a PASRR number ends in the letter "B" it has no expiration date. The hospital usually obtains it for us. I notify the health information director, and the MDS Coordinator of PASRR status. The number is documented in the chart. (Resident #3 and Resident #5) are PASRR Level II. (Resident #3) has been a level 2 since he was admitted to the facility. He has always been a PASRR 2. (Resident #5) just received his permanent number in October of 2016. PASRR should be coded on the MDS." An interview was conducted on 2/28/17 at 3:55 PM with the Director of Nursing (DON). She stated information is collected from nursing assessments, physician orders, consult notes, face to face assessments, hospital records, and nursing assistant documentation. She stated PASRR information was collected by the Social Worker (SW). She also stated Resident #5 received hospice care since he was re-admitted to the facility in January. The DON stated her expectation was for the MDS to be accurate since	F 278	determinations of all future admissions/readmissions into the Electronic Medical Record allowing the MDS Coordinator access to the full PASARR determination. The MDS Coordinator received a refresher on the coding of Hospice services on 3/6/17 by the Administrator. Quality Assurance The Administrator or Designee will monitor this issue during the Daily, Monday through Friday, Clinical Quality Assurance Meeting. The monitoring will include verifying that PASARR determinations are scanned into the electronic medical record for all admissions and readmission. The monitoring will include verifying that any resident that elects hospice services has it properly coded on the MDS. Results will be reported weekly to the QOL/QA committee and corrective action initiated as appropriate. This will be done for three months and extended as needed until 100% compliance is achieved. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	

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F 278	Continued From page 5 individualized care plans were formulated from an accurate MDS. An interview was conducted on 2/28/17 at 4:05 PM with the SW. She stated the outside hospitals applied for PASRR before a resident was admitted to the facility. She also stated if a resident arrived from home she completed the PASRR application. She also stated the MDS coordinator was responsible for Section "A" of the MDS. An interview was conducted on 2/28/17 at 4:15 PM with the Administrator. She stated, "The PASRR form is brought to the business office and filed. The number gets scanned into our electronic medical record. The MDS Coordinator is aware of Level II PASRR's because we discuss admissions in our daily stand-up meeting. She (the MDS Coordinator) is to complete the MDS accurately. I expect PASRR to be coded correctly in the MDS, the entire MDS should be coded correctly. The MDS Coordinator is responsible for ensuring the whole MDS is accurate. (Resident #5 and Resident #3) should have had PASRR coded on the MDS and (Resident #5) should have hospice care coded on his MDS but neither one is completed correctly." The MDS Coordinator was not available for an interview.	F 278		