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 _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROSS CREEK HEALTH CARE	1719 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 679 SS=E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide an ongoing activity program which met individual interests and needs to enhance the quality of life for 4 of 4 residents reviewed for activities (Resident #19, Resident #9, Resident #16 and Resident #33). Findings included: 1-Record review of Resident #19 revealed she was admitted to the facility with diagnoses which included Hypertension and Heart Failure. Review of the Annual Minimum Data Set (MDS) indicated Resident #19 was cognitively intact and required limited assistance of 1 staff member with all of her Activities of Daily Living (ADLs). The MDS further revealed it was very important for her to do things with groups of people and to do her favorite activities. An Activity Assessment completed by the facility Activity Director and dated 3/2/2018 was reviewed. The Assessment revealed Resident #19 was an active participant in activities and she desired to be invited to out of room activities. An interview was conducted with Resident #19 on	F 679	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 679 SS= E Corrective Action for Residents Affected Resident #9 and #19 interviews indicated desires for increase social activities. Please see May activity calendar (Attachment #1) and note increased offerings of social activities. Resident #33 indicated desire for craft space. The craft room creation has been finalized. Resident #16 indicated a desire for crafts	5/15/18

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

Electronically Signed | 05/16/2018

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F 679	Continued From page 1 4/23/2018 at 2:27 PM. Resident #19 was up in her wheelchair in her room. She was alert, oriented and pleasant. The resident reported she loved to attend activities but the facility did not provide them like they used to. The resident reported if there were activities offered she would surely attend. An interview was conducted with the facility Activity Director (AD) on 4/24/2018 at 3:24 PM. The AD reported she was familiar with Resident #19. The AD indicated since Resident #19 was alert and oriented most of her activities were self-directed. The AD indicated some examples of self-directed activities were reading and watching television in her room. The AD stated the resident attended the beauty shop on Mondays and that was an activity. The AD indicated there were not as many group and social activities as there were previously for the residents. The AD stated there was absolutely a need for more activities for the residents. The AD also stated the residents should be offered more activities. The AD did not give an explanation for the lack of activities for the residents. An interview was conducted with the Administrator on 2/24/2018 at 4:14 PM. The Administrator reported she was aware there were issues with facility activities. The Administrator indicated the leadership staff at the facility were trying to work on resolution of the issues and the lack of scheduled activities for the residents. The Administrator stated the expectation was for the facility to provide activities to meet the needs of all the residents. 2-Record review revealed Resident #9 was admitted to the facility on 7/22/2016 with diagnoses which included Hypertension and a history of cervical spine surgery. Review of the	F 679	and for communion through church services. Our craft room development has been finalized. Group led crafts are begin on the attached May calendar when supplies arrive and will continue in future months. The attached calendar also includes rotating devotional services at our facility. These groups have agreed to serve communion on Sundays. Corrective Action for Resident Potentially Affected All residents have been given a copy of the May activity calendar and are offered an increased amount and variety of social and group activities. Communion has been arranged through local church groups on a rotational basis. Systemic Changes The Activity Director received education on this regulation from the Administrator on 5/15/18 (Attachment # 2) will offer varied social and group activities and crafts each month on an ongoing basis. Communion will be offered as able from local church groups. Quality Assurance The Administrator will monitor this through the Activity Participation Tool (Attachment #3). The Administrator will interview four residents with this tool weekly for four weeks, and monthly for three months, or until resolved by the QA committee. Results will be reported weekly to the QA committee and corrective action initiated as appropriate. The QA committee is the main quality assurance committee. This	

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F 679	Continued From page 2 Minimum Data Set (MDS) dated 2/19/2018 indicated Resident #9 was cognitively intact and required limited to total assistance with all Activities of Daily Living (ADLs). The MDS further revealed it was very important for Resident #19 to do things with groups of people and to do her favorite activities. An Activity Assessment completed by the facility Activity Director and dated 2/19/2018 was reviewed. The Assessment revealed Resident #9 was an active participant in activities and she desired to be invited to out of room activities. An interview was conducted with Resident #9 on 4/24/2018 at 8:28 AM. The resident was alert and oriented and sitting in her wheelchair in her room watching television. Resident #9 stated there were hardly any activities offered at the facility. The resident stated she would love to see more activities and did not understand why things weren't offered. An interview was conducted with the facility Activity Director (AD) on 4/24/2018 at 3:24 PM. The AD reported she was familiar with Resident #9. The AD indicated Resident #9 was alert and oriented so most of her activities were self-directed. The AD indicated some examples of self-directed activities were reading and watching television in her room. The AD stated the Resident #9 would refuse activities. The AD reported she did not keep attendance for any activities and did not have documentation of Resident #9's refusals. The AD stated it was difficult to find activities to meet the needs of all the residents as there were many different personalities to deal with. The AD indicated there were not as many group and social activities as there were previously for the residents. The AD stated there was absolutely a need for more activities for the residents. The AD also stated the	F 679	regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Social Services Coordinator/Activity Director, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	

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residents should be offered more activities. The AD did not give an explanation for the lack of activities for the residents.
An interview was conducted with the Administrator on 2/24/2018 at 4:14 PM. The Administrator reported she was aware there were issues with facility activities. The Administrator indicated the leadership staff at the facility were trying to work on resolution of the issues and the lack of scheduled activities for the residents. The Administrator stated the expectation was for the facility to provide activities to meet the needs of all the residents.
3. A review of the medical record revealed Resident #33 was admitted 10/5/2017 with diagnoses of Multiple Sclerosis, chronic pain, migraine, bipolar disorder, depressive disorder, obesity and general anxiety disorder.
The Admission Minimum Data Set (MDS) dated 10/12/2017 noted Resident #33 to be cognitively intact and was independent to total assist for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons.
On 4/23/2018 at 2:07 PM, Resident #33 was interviewed in regard to her care at the facility. When asked if she attended any of the activities at the facility, Resident #33 stated "there are no activities here." Resident #33 went on to say there was nothing she was interested in except there was supposed to be a craft area being arranged at present. Resident #33 indicated she had told another resident she would assist her in making a collage of pictures. Resident #33 noted the area is being used for another resident to watch movies and there really isn't enough room for the other resident and residents doing crafts.
In an interview on 4/26/2018 at 11:08 AM, the Activity Director stated the activities calendar is filled out the week before the first of the next

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month. The current activities calendar was discussed with the Activity Director. Sunday, April 22, 2018 was noted to be Earth Day on the activity calendar. The Activity Director stated "we really didn't do anything for Earth Day." Thursday was Store Day and the Director stated this was the day she went to the store for residents and it was on the calendar to remind the residents if they wanted her to purchase anything for them. When asked of the residents went to the store, the Activity Director stated "once in a while we take a couple of them." The Activity Director stated there are 1:1 activities with residents in their rooms 3 times per week and it is documented in the plan of care in the computer system.
On 4/26/2018 at 1:45 PM, in an interview, the Director of Nursing stated her expectation was the facility would improve the activities and the activities would appeal more to the residents.
On 4/26/2018 at 1:55 PM, the Administrator stated her expectation was activities would be made available to all residents.

4. A review of medical records revealed Resident #16 was admitted 8/27/2010 with diagnoses of schizophrenia, paraplegia, other chronic pain, pressure ulcer Stage 4, neurogenic bladder, depression and nicotine dependence.
The Significant Change Minimum Data Set (MDS) dated 3/1/2018 noted Resident #16 was cognitively intact and needed set up help only for all Activities of Daily Living, with the assistance of one person for dressing.
On 4/23/2018 at 2:40 PM, in an interview, Resident #16 was asked if she attended any of the activities in the facility. The Resident replied "what activities?" Resident #16 went on to state there was beauty shop on Mondays, church on

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Wednesdays and the Activities Director went to the store on Thursdays. Resident #16 indicated she would enjoy crafts like beads and painting. Resident #16 noted she is Catholic and would like to be able to take communion on Sunday.
In an interview on 4/26/2018 at 11:08 AM, the Activities Director (AD) stated the calendar for activities is filled out the week before the first of the next month. The activities calendar was noted to have Earth Day listed on Sunday, April 22. The AD stated the facility really did not do anything for Earth Day. When asked about going to the store on Thursdays, the AD stated that was on the calendar so that residents would know she was going to the store and could make purchases for the residents. The AD noted she takes a couple of residents to the store once in a while. The AD stated 1:1 is done for residents in their room and there is a lady in the community that comes to help out for 4 hours/week and helps with 1:1 visits.
On 4/26/2018 at 11:43 AM, the AD was asked to show the 1:1 visits for Resident #34 and Resident #4. When the AD went to the record of Resident #4 there was one date in the box for 1:1 activities. When asked why the boxes were blank, the AD stated Resident #4 refused all 1:1 activities except one. When asked about Resident #34, the AD stated Resident #34 did not get 1:1 activities because he was social and attended activities. The AD stated with the facility census growing, more activities would be required.
The Director of Nursing stated, in an interview on 4/26/2018 at 1:45 PM, her expectation was the facility needed to improve with activities that would appeal to the residents.
On 4/26/2018 at 1:55 PM, the Administrator stated her expectation was the activities would be made available to all residents in the facility.

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F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F 756		5/15/18

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F 756	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to complete a review for abnormal involuntary movement scale assessment in the required time frame for one of four residents reviewed (Resident #23). Findings included: A review of medical records revealed Resident #23 was admitted 6/30/2015 with diagnoses of Alzheimer's disease, vascular dementia with behaviors, Diabetes, unspecified psychosis, mood disorder and depression. The most recent Quarterly Minimum Data Set (MDS) dated 3/14/2018 noted Resident #23 to be severely impaired for cognition and needed extensive assistance for all Activities of Daily Living with the physical assistance of one to two persons. No rejection of care was noted. Delusions were indicated. The Annual MDS dated 6/20/2017 indicated, in the Care Area Assessment, a focus of cognitive loss/dementia and this area went to care plan. The care plan dated 3/8/2018 noted a focus of Resident #23 received antipsychotic medication related to diagnosis of major depressive disorder and psychosis with risk for adverse side effects. The goal was to minimize adverse reactions to antipsychotic meds. Interventions included: Administer medications as ordered. Consulting pharmacist to review psychotropic meds quarterly and as needed for possible changes or deductions. Discuss possible side effects of medication with resident and responsible party. Mental Health consultation as needed. Perform Abnormal Involuntary Movement Scale (AIMS) every six months. Report involuntary movements, etc. to nurse immediately. Report sedation or change in mental functioning to nurse, if noted.	F 756	F 756 SS= D Corrective Action for Resident Affected The recommended Abnormal Involuntary Movement Scale (AIMS) for Resident #23 was completed on 1/24/18. Corrective Action for Resident Potentially Affected The Director of Nursing and MDS Coordinator audited all residents requiring AIMS assessments on 1/24/18 and any required AIMS were completed at that time. Systemic Changes The DON and MDS Coordinator received education on this regulation on 5/15/18 (Attachment #4) and will print all pharmacy recommendations and store them in a binder. The DON or MDS Coordinator will review to ensure that clinical staff have followed through with recommendations and will indicate this on the paper copy in the binder (an example has been attached as Attachment #5). Quality Assurance The Administrator will review the pharmacy recommendations each month to verify that the DON has indicated that each item has been completed. Results will be reported weekly to the QA committee and corrective action initiated as appropriate, for three months or until resolved by the QA committee. The QA committee is the main quality assurance	

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F 756	Continued From page 8 A review of assessments revealed one AIMS review completed on 1/24/2018. On 4/25/2018 at 9:15 AM, in an interview, the Director of Nursing (DON) stated the AIMS had changed and was included in the antipsychotic review. On 4/25/2018 at 10:30 AM, the DON stated the antipsychotic was initiated on 5/10/2017 and there was no baseline AIMS. The DON stated the next AIMS would have been in November, but was not completed until January, 2018. A review of the consultant Pharmacist monthly review noted a recommendation for AIMS made in May, 2017 and monthly thereafter until November, 2017 when the 6 month AIMS was due. There was a recommendation for AIMS in December, 2017 and in January, 2018. In an interview on 4/25/2018 at 11:33 AM, the consultant Pharmacist stated when she comes to the facility for the monthly review, she sends a report with the recommendations via email. The Pharmacist indicated she tries to recommend the AIMS every month if it is not done. On 4/25/2018 at 2:29 PM, in an interview, the DON stated she had missed the recommendation for the AIMS from the Pharmacist from the original order in May, 2017. On 4/26/2018 at 1:44 PM, the DON stated her expectation was the AIMS would be done every six months.	F 756	committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Social Services Coordinator/Activity Director, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	