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 _____	C 02/20/2020

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
E 000	Initial Comments An unannounced Recertification survey was conducted on 02/17/20 through 02/20/20.. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #XDL411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 02/17/20 through 02/20/20. Event ID# XDL411. Three of the 19 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F 550		3/13/20

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

Electronically Signed | 03/09/2020

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 _____	C 02/20/2020

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 550	Continued From page 1 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review the facility failed to maintain dignity when a staff member failed to knock on the resident's door or announce their presence before entering the resident's room for 1 (Resident #17) of 5 residents reviewed for dignity. The findings included: Resident #17 was admitted to the facility on 10/5/17 with diagnoses which chronic pain, depression and anxiety disorder. Resident #17's quarterly Minimum Data Set dated 12/29/19 indicated she was cognitively intact and had no behaviors. She required extensive to total assistance with activities of daily living except she was independent with locomotion.	F 550	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. Corrective Action for Residents Affected NA#2 and other staff present received 1:1 education from the Administrator on knocking on resident doors on 2/17/20. On 3/3/20, Resident #17 was interviewed by Social Services Coordinator regarding staff knocking on the door and resident	

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 _____	C 02/20/2020

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 550	Continued From page 2 During an interview with Resident #17 on 2/17/20 at 12:12 PM Nursing Assistant (NA) #2 entered the resident's room without knocking or asking permission to enter. On 2/17/20 at 12:12 PM NA #2 stated sometimes she knocks on a resident's door, but this time she forgot to knock. NA #2 stated she was just picking up Resident #17's lunch tray in the room. On 2/18/20 at 9:20 AM Resident #17 was interviewed. Resident #17 stated "For the most part they (staff) treat you like a second-rate citizen. It makes me feel bad when they just come in without knocking." Resident #17 stated the staff enter her room daily without knocking on the door or announcing their presence before entering. During an interview with Nurse #1 on 2/18/20 at 11:30 AM she said all staff should knock on the resident's door and ask permission before entering the resident's room every time they visit a resident's room.	F 550	states this has improved. Corrective Action for Resident Potentially Affected Formal in-service education began on 03/02/20 by the Administrator for all staff. The in-service topics included: Resident Rights regarding dignity, including knocking on doors, and valuing resident□s private space. The Administrator will ensure that any employee who has not received this training by 03/09/20 will not be allowed to work until the training is completed. Systemic Changes Formal in-service education began on 03/02/20 by the Administrator for all staff. The Administrator will ensure that any employee who has not received this training by 03/09/20 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff. The Social Services Coordinator will interview three residents per week for four weeks, and monthly for three months or until resolved by the QA committee regarding staff knocking on doors and other dignity concerns, using the QA Tool for Identifying Dignity Concerns, and corrective action will be implemented as appropriate. Quality Assurance The Social Services Coordinator will monitor this through the QA Tool for Identifying Dignity Concerns. The Social Services Coordinator will interview three	

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 _____	C 02/20/2020

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 550	Continued From page 3	F 550	alert and oriented residents about staff knocking and other dignity concerns with this tool weekly for four weeks, and monthly for three months, or until resolved by the QA committee. and corrective action will be implemented as appropriate. 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 regularly scheduled daily 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.	
F 559 SS=B	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident and family interviews, staff interviews, and record review the facility failed to	F 559	Corrective Action for Residents Affected Resident #32, #83, and #16 or their	3/13/20

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 _____	C 02/20/2020

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 559	Continued From page 4 provide written notice of a room change for 3 of 3 residents reviewed for room change (Resident #32, Resident #83 and Resident #16). The findings included: 1. Resident #32 was admitted to the facility on 1/30/20 with diagnoses that included chronic kidney disease and congestive heart failure. Resident #32's most recent Minimum Data Set (MDS) assessment dated 2/6/20 coded her as moderately cognitively impaired. Review of a social work progress note dated 2/17/20 indicated Resident #32 was verbally notified of a room change. An interview was conducted with Resident #32 on 2/18/20 at 8:30 AM who stated she was notified of a room change on 2/17/20 when she returned from therapy and discovered she had been assigned a new room. She indicated no reason was given for the room change. An interview was conducted the social worker on 2/18/20 at 9:13 AM who stated a written notice of room change was not given to Resident #32. She stated she was unaware a written notice was required. During an interview with the Administrator on 2/20/20 at 1:30 PM she stated she was unaware that written notices of room changes were required. She reported the residents were moved on 2/17/20 because the beds they were in were converted to licensed only beds on 1/1/20. She stated Resident #32 was a skilled resident.	F 559	Responsible Party were given verbal notification of room change on 2/17/20 and vocalized agreement with room change, location, and timing of room change. Residents or Responsible Party were issued written notification of these room changes on 3/3/20. (Attachment #4) Corrective Action for Resident Potentially Affected The Administrator audited all room changes in last 30 days (Attachment #4). 2 of 27 other residents required written notice of room change/roommate. Written notifications were issued on 3/3/20 for 2 of 2 residents (Attachment#4) by the Administrator. Systemic Changes In-service education began on 03/02/20 by the Administrator for all staff (Attachment #2). The in-service topics included: Resident Rights regarding room change, including written notification of room change and roommate. The Administrator will ensure that any employee who has not received this training by 03/09/2020 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff. In-service education began on 03/02/20 for the Social Services Coordinator and Business Office Manager including the above information and a letter template to be used for these notifications effective 03/02/20 (Attachment #6), and a review of SSC responsibility to provide written notice of	

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 _____	C 02/20/2020

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 559	Continued From page 5 2. Resident #83 was admitted to the facility on 2/12/20 with diagnoses that included hypertension and dementia. A social work progress note dated 2/17/20 revealed Resident #83 was verbally notified of a room change. An interview was conducted with Resident #83 on 2/18/20 at 9:53 AM and he stated that he could not recall a room change on 2/17/20. An interview was conducted the social worker on 2/18/20 at 9:13 AM who stated a written notice of room change was not given to Resident #83. She stated she was unaware a written notice was required. During an interview with the Administrator on 2/20/20 at 1:30 PM she stated she was unaware that written notices of room changes were required. She reported the residents were moved on 2/17/20 because the beds they were in were converted to licensed only beds on 1/1/20. She stated Resident #83 was a skilled resident. 3. Resident #16 was admitted to the facility on 8/30/15 with diagnoses that included diabetes mellitus and hypothyroidism. Resident #16's most recent Minimum Data Set (MDS) assessment dated 12/24/19revealed he was assessed as moderately cognitively impaired by staff interview. A social work progress note dated 2/17/20 revealed Resident #16 was verbally notified of a room change. The note further stated his responsible party was notified via phone.	F 559	room change. A reminder has been added to the existing Daily Stand-Up sheet for the Room Change topic that reminds the SSC to issue a written notice prior to room change. This information has been integrated into the standard orientation training for new Business Office Managers and Social Service Coordinators. Quality Assurance The Business Office Manager will monitor this through the Room Change Tracking and Notification Tool (Attachment #7). The BOM or designee will record all room changes with this tool weekly for four weeks then monthly for three months, or until resolved by the QA committee. Results will be reported weekly by the Administrator to the QA committee and corrective action initiated as appropriate. The QA committee is the main quality assurance committee. This regularly scheduled daily 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.	

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 _____	C 02/20/2020

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 559	Continued From page 6 An interview was attempted with Resident #16 on 2/18/20 at 10:00 AM and he was unable to be interviewed. An interviewed was conducted with Resident #16's responsible party on 2/18/20 at 4:45 PM who stated she received a telephone call stating Resident #16 would be moved. She reported that a reason for the move was not given. Resident #16's responsible party stated she did not receive written notification of the room change. An interview was conducted the social worker on 2/18/20 at 9:13 AM who stated a written notice of room change was not given to Resident #32. She stated she was unaware a written notice was required. During an interview with the Administrator on 2/20/20 at 1:30 PM she stated she was unaware that written notices of room changes were required. She reported the residents were moved on 2/17/20 because the beds they were in were converted to licensed only beds on 1/1/20. She stated Resident #16 was a skilled resident.	F 559		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F 580		3/13/20

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 _____	C 02/20/2020

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 580	Continued From page 7	F 580		

mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

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 _____	C 02/20/2020

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 580	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to notify the responsible party of behavioral incidents for 1 of 5 residents reviewed for accidents (Resident #16). The findings included: Resident #16 was admitted to the facility on 8/30/15 with diagnoses that included diabetes mellitus and hypothyroidism. Resident #16's most recent Minimum Data Set (MDS) assessment dated 12/24/19 revealed he was assessed as moderately cognitively impaired by staff interview. He was assessed as having verbal behaviors towards others 1-3 days of the 7-day lookback period. A progress note written by the Administrator dated 4/8/19 revealed Resident #16 got into an altercation with another resident who grabbed his wheelchair. The note stated Resident #16 tapped the other resident on her hand which caused her to let go of his wheelchair. There was no documentation of notification of his responsible party. A nursing progress note dated 11/28/19 revealed Resident #16 pushed other residents out of his way, so he could roll by in his wheelchair. There was no documentation of notification of his responsible party. An interview was conducted with Resident #16's responsible party on 2/18/20 at 4:45 PM who stated she was not notified of behavioral incidents on 4/8/19 or 9/5/19. She stated she was made	F 580	Corrective Action for Residents Affected The Responsible Party for Resident #16 was notified of these behaviors on 2/18/20. On 3/4/20, the Administrator and Responsible Party reviewed all behavioral incidents in the past 30 days for this resident and discussed current plan of care. Corrective Action for Resident Potentially Affected On 3/4/20-3/5/20 the Social Services Coordinator audited behavioral incidents for all residents for previous 30 days to verify notification to RP. 1 of 29 other residents was identified with new behaviors without documentation of RP notification. Social Service Coordinator reviewed behavior with RP of that resident on 3/5/2020 and RP was updated with all current interventions and plan of care. Systemic Changes In-service education began on 03/02/20 by the Administrator for all staff. The in-service topics included: types of changes in condition and what to do when a change in condition is noted, including RP notification. The Administrator will ensure that any employee who has not received this training by 03/09/2020 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff. Quality Assurance	

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 _____	C 02/20/2020

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 580	Continued From page 9 aware of these incidents after Resident #16 was involved in an incident on 12/1/19 and the facility was recommending discharge. An interview was conducted with the Administrator 2/20/19 at 11:22 PM who stated she did not notify Resident 16's responsible party of the 4/8/19 incident. She indicated it had been some time since the incident and couldn't remember why she did not notify the responsible party. The administrator further indicated Resident #16's responsible party should have been notified of behavioral incidents involving Resident #16. During a phone interview with Nurse #3 on 2/20/19 at 11:32 AM she stated she did not notify Resident #16's responsible party of the 9/5/19 incident. She indicated it had been some time since the incident and couldn't remember why she did not notify the responsible party. Nurse #3 stated she was positive if she didn't document it in the note the notification was not made. An interview was conducted with the Director of Nursing on 2/20/19 at 11:16 AM who indicated Resident #16's responsible party should have been notified of behavioral incidents involving Resident #16.	F 580	The Administrator, Director of Nursing, or Nurse Supervisor will monitor this through the QA Tool for Identifying Changes in Condition. The Administrator, DON or Nurse Supervisor will review incident reports and progress notes for behavioral changes in condition and RP notification 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 regularly scheduled daily 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.	
F 582 SS=B	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in	F 582		3/13/20

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 _____	C 02/20/2020

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 582	Continued From page 10	F 582		

nursing facility services under the State plan and for which the resident may not be charged;
(B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and
(ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section.

§483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate.
(i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.
(ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.
(iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.
(iv) The facility must refund to the resident or resident representative any and all refunds due

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 _____	C 02/20/2020

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 582	Continued From page 11 the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Residents #84 and Resident #85). The findings included: 1. Resident #84 was admitted to the facility on 11/11/19 with diagnoses that included congestive heart failure and chronic obstructive pulmonary disease. She was discharged from the facility on 11/16/19. Record review revealed that Resident #84 was not given the CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) or documentation of circumstances of a resident-initiated discharge. An interview was conducted with the Administrator on 2/20/20 at 1:30 PM who indicated she was issuing CMS-10123 NOMNC during the period Resident #84 was in the facility. She stated was unaware that the CMS-10123 NOMNC was required if a resident planned to return to the community after termination of rehabilitation services.	F 582	Corrective Action for Residents Affected Resident #84 and #85 participated in their discharge planning and agreed to their discharge plan as resident-initiated discharges with no NONMC required. The Business Office Manager updated billing notes in Point Click Care on 03/03/20 to clarify that #84 and #85 discharges were at the request of the resident. On 03/04/20 the Social Services Coordinator entered clarification notes for these residents in the clinical record (Attachment#10). Corrective Action for Resident Potentially Affected On 03/02/20, the Business Office Manager and Administrator audited all discharges in the previous six months to verify documentation for resident-initiated discharges or that Non-Coverage letters were in place (Attachment #10). No Non-Coverage letters needed to be issued. Clarifications were updated in Point Click Care on 03/03/20 by Business Office Manager and on 03/04/20 Social Service Coordinator regarding discharge terminology for 10 of 22 Medicare resident-initiated discharges in the previous six months.	

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 _____	C 02/20/2020

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 582	Continued From page 12 2. Resident #85 was admitted to the facility on 8/7/19 with diagnoses that included dementia and diabetes mellitus. He was discharged from the facility on 9/4/19. Record review revealed that Resident #85 was not given the CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) or documentation of circumstances of a resident-initiated discharge. An interview was conducted with the Administrator on 2/20/20 at 1:30 PM who indicated she was issuing CMS-10123 NOMNC during the period Resident #85 was in the facility. She stated was unaware that the CMS-10123 NOMNC was required if a resident planned to return to the community after termination of rehabilitation services.	F 582	Systemic Changes In-service education was provided on 03/02/20 by the Administrator for the Business Office Manager and Social Services Coordinator (Attachment #6). The in-service topics included Medicaid/Medicare Coverage/Liability Notices, Notice to Medicare Provider Non-Coverage (NOMNC) and Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN), and documentation in the Clinical and Admin side of Point Click Care regarding discharges. This information has been integrated into the standard orientation training for Social Services Coordinators and Business Office Managers. The existing Daily stand-up sheet has been edited to include a reminder to the BOM to verify NONMC or ABN status with every payer status change. Quality Assurance The Social Services Coordinator or designee will monitor this through the Beneficiary Notice Tool (Attachment #11). The Social Services Coordinator will record all Medicare A and B discharges weekly for four weeks then monthly for three months, or until resolved by the QA committee. Results will be reported weekly by the Administrator to the QA committee and corrective action initiated as appropriate. The QA committee is the main quality assurance committee. This regularly scheduled daily meeting is attended by the Administrator, Director of Nursing/MDS Coordinator, and Social	

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 _____	C 02/20/2020

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 582	Continued From page 13	F 582	Services Coordinator/Activity Director, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, staff, resident and family interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of antipsychotic medication, anticoagulant medication, opiate medication, falls and bed certification for 6 of 18 residents whose MDS assessments were reviewed (Resident #8, Resident #13, Resident #20, Resident #29, Resident #32 and Resident #83). The findings included: 1. Resident #8 was admitted to the facility on 10/17/16 with diagnoses that included hypertension and diabetes mellitus. Resident #8's August 2019 Medication Administration Record revealed he received antipsychotic medication during the 7-day look back period in August. Resident #8's annual Minimum Data Set (MDS) assessment dated 8/29/19 revealed in section N, Resident #8 received antipsychotic medication 7 days during the 7-day lookback period. The	F 641	Corrective Action for Residents Affected " The MDS for Resident #8 was corrected on 03/02/20 by modifying the Minimum Data Set assessment with an Assessment Reference Date of 08/29/19 in order to correct miscoding of Antipsychotics in Section N. This correction was completed by the facility Minimum Data Set Coordinator. The corrected assessment was re-submitted and accepted by the state database on 03/04/20 (Attachment #12). " The MDS for Resident #13 with Assessment Reference Date of 09/06/19 was corrected on 03/02/20 by the facility Minimum Data Set Coordinator in order to correct the coding of Anticoagulants in Section N. This assessment was re-submitted and accepted into state database on 03/04/20. The Minimum Data Set assessment with Assessment Reference Date of 12/13/19 was modified on 02/21/20 by the facility Minimum Data Set Nurse in order to correct the coding for Anticoagulants and Opiates in Section	3/13/20

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 _____	C 02/20/2020

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 641	Continued From page 14 assessment was coded in question N0450A as not receiving antipsychotic medication. During an interview with the Director of Nursing on 2/19/20 at 2:18 PM she reported the MDS nurse who completed the 8/29/19 assessment was no longer employed by the facility. She stated Resident #8's assessment was inaccurate and should have reflect the use of antipsychotic medication. During an interview with the Administrator on 2/20/19 at 1:30 PM she indicated Resident #8's assessment should have coded accurately to reflect the use of antipsychotic medication. 2. Resident #13 was admitted to the facility on 8/30/19 with diagnoses that included diabetes mellitus and heart failure. Resident #13's Medication Administration Records for August 2019, September 2019, and December 2019 revealed no anticoagulant or opiate medication during the 7-day lookback period in September and December. Resident #13's annual Minimum Data Set (MDS) assessment dated 9/6/19 revealed in section N, Resident #13 received anticoagulant medication 7 days during the 7-lookback period. Resident #13's quarterly MDS assessment dated 12/13/19 revealed in section N, Resident #13 received anticoagulant medication 7 days during the 7-day lookback period and opiate medication 1 day during the 7-day lookback period. During an interview with the Director of Nursing (DON) on 2/19/20 at 2:18 PM she reported the	F 641	N. The corrected assessment was re-submitted and accepted by the state database on 02/24/20. The MDS for Resident #13 with Assessment Reference Date of 11/09/19 was corrected on 03/02/20 by the facility Minimum Data Set Coordinator in order to correct the coding Section N. This assessment was re-submitted and accepted into state database on 03/04/20. (Attachment #12) " The MDS for Resident #20 was corrected on 02/19/20 by the facility Minimum Data Set Coordinator. The assessment with Assessment Reference Date of 01/04/20 was modified by the facility Minimum Data Set Nurse in order to correct the coding for Falls with Major Injury in Section J. The corrected assessment was re-submitted and accepted by the state database on 02/20/20 (Attachment #12). " The Administrator spoke to the NC RAI Coordinator on 03/02/2020 about correcting the MDS for residents #29, #32, and #83, and received instructions for completing MDS 3.2 Manual Assessment Correction/Deletion Requests for the affected assessments (Attachment #12). o For resident #29, on 3/9/20 the Administrator submitted Deletion Requests for #29 assessments with the following ARD dates: 1/16/20, 1/23/20, 1/24/20, 1/28/20, and 2/4/20. o For resident #32, on 3/9/20 the Administrator submitted Deletion	

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 _____	C 02/20/2020

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 641	Continued From page 15 MDS nurse who completed the 9/5/19 assessment was no longer employed by the facility. She reported an antiplatelet medication was erroneously coded as an anticoagulant on the 9/5/19 assessment. The DON stated she is currently the MDS nurse in the facility and on the 12/13/19 assessment an antiplatelet medication was erroneously coded as an anticoagulant. She further stated Resident #13's 12/13/19 assessment was erroneously coded for receiving opiates 1 day during the 7-day lookback period. During an interview with the Administrator on 2/20/19 at 1:30 PM she indicated medications should have been accurately coded on Resident #13's 9/6/19 and 12/13/19 assessments. 3. Resident #20 was admitted to the facility on 10/22/18 with diagnoses which included dementia, atrial fibrillation and neuromuscular dysfunction of the bladder. A review of the quarterly Minimum Data Set (MDS) dated 1/4/20 revealed Resident #20 was severely cognitively impaired. He required extensive to total assistance with all activities of daily living. He had an indwelling catheter. The MDS indicated Resident #20 had 2 falls with no injury, 2 or more falls with nonmajor injury and 1 fall with major injury. A review of the care plan dated 1/24/20 revealed Resident #20 had actual falls related to confusion, deconditioning, limited mobility and hemiplegia. A review of Resident #20's progress notes revealed he did not sustain a major injury during any of the falls for the last year.	F 641	Requests for #29 assessments with the following ARD dates: 1/30/20 and 2/6/20. o For resident #83, on 3/9/20 the Administrator submitted Deletion Requests for #83 assessments with the following ARD dates: 2/12/20. Corrective Action for Resident Potentially Affected A 100% audit of all current residents will be conducted in order to identify any other resident who may have been affected by this alleged deficient practice. All current residents most recent Omnibus Budget Reconciliation Act Minimum Data Set assessment will be reviewed in order to determine if the following areas were accurately coded: " Section J Falls with Major Injury " Section N Antipsychotic, Anticoagulant and Opioid Use All current skilled nursing residents will be reviewed to ensure that they are appropriately assigned to Medicare and Medicaid certified beds. These audits will be completed by the Regional Minimum Data Set Consultant and will be completed no later than 03/12/20. Any coding errors that are identified during the audit will be immediately modified and corrected and re-submitted to the state database. Any current skilled nursing resident identified as being inappropriately assigned to a non-certified bed will be appropriately re-assigned to a Medicare/Medicaid certified bed. The Administrator audited all other residents known to be admitted to beds	

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 _____	C 02/20/2020

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 641	Continued From page 16 A review of the fall investigations on 2/19/20 at 11:30 AM revealed Resident #20 did not sustain a major injury for any of his falls. On 2/19/20 at 5:00 PM the Administrator stated she and the interdisciplinary team reviewed the falls documentation for Resident #20 and he had not sustained a major injury with any of the falls. The Administrator reported the MDS nurse was new to the position was learning how to code the MDS. The Administrator said the MDS nurse thought the skin tear the resident sustained from his urinary catheter was a major injury. The Administrator said the MDS was coded wrong. 4. Resident #29 was admitted to the facility on 1/25/20 into room 404A. The entry Minimum Data Set (MDS) dated 1/28/20 indicated in section A0410 Resident #29 was in a Medicare/Medicaid Certified bed. The MDS section A1300B indicated Resident #29 was admitted to room 404A. The Nursing Home Licensure & Certification Section approved a bed change request from the nursing home and issued a nursing home license effective 1/1/2020. The license indicated 30 adult care home beds in rooms 302, 304, 306, 308, 310 and rooms 401-410 effective 1/1/2020. An observation on 2/17/20 at 11:00 AM revealed Resident #29 was residing in room 404A. On 2/18/20 at 9:35 AM the Administrator reported all the beds on the 400 hall were adult care home beds so Resident #29 was in an adult care home bed until yesterday when Resident #29 was moved to room 303. She indicated the resident	F 641	302, 304, 306, 308, 310, and 401-410 after 01/01/2020 to verify MDS Coding regarding A0410 on 03/02/2020. 5 other residents required MDS 3.2 Manual Assessment Correction/Deletion Requests. The Administrator submitted Deletion Requests for these residents on 03/09/2020 (Attachment #12). Systemic Changes On 03/05/20, the Regional Minimum Data Set Consultant completed an in-service training for the facility Minimum Data Set Coordinator that included the importance of thoroughly reviewing the medical record prior to completion of all Sections of the Minimum Data Set assessment (Attachment #13). Special emphasis was on correctly counting and coding medications such as Antipsychotic, Opioids, and Anticoagulants medications. Another area that was emphasized was the importance of a thorough record review in order to be able to accurately code Section J for Falls with Major Injury. This information has been integrated into the standard orientation training for new Minimum Data Set Coordinators. The Administrator or designee will audit the coding of: Section N □ Antipsychotic, Anticoagulant and Opioid use; Section J-Falls with Major Injury of the Minimum Data Set Assessment using the quality assurance survey tool entitled Accurate Minimum Data Set Coding Audit Tool. The Administrator or designee will audit skilled nursing residents to ensure that they are assigned appropriately to Medicare/Medicaid certified beds using	

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 _____	C 02/20/2020

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 641	Continued From page 17 should not have been admitted to the adult care home bed. 5. Resident #32 was admitted to the facility on 1/3/20 into room 405A. A review of the entry Minimum Data Set dated 1/30/20 indicated in section A0410 Resident #32 was in a Medicare/Medicaid Certified bed. Section A1300B indicated Resident #32 was in room 405A. The nursing home licensure & certification section approved a bed change request from the nursing home and issued a nursing home license effective 1/1/2020. The license indicated 30 adult care home beds in rooms 302, 304, 306, 308, 310 and rooms 401-410 effective 1/1/2020. An observation on 2/17/19 at 11:10 AM revealed Resident #32 was residing in room 405A. On 2/18/20 at 9:35 AM the Administrator reported all the beds on the 400 hall were adult care home beds so Resident #32 was in an adult care home bed until yesterday when Resident #32 was moved to room 305. She indicated the resident should not have been admitted to the adult care home bed. 6. Resident #83 was admitted to the facility on 2/12/20 into room 406A. A review of the entry Minimum Data Set dated 2/12/20 indicated in section A0410 Resident #83 was in a Medicare/Medicaid Certified bed. Section A1300B indicated Resident #83 was in room 406A.	F 641	the quality assurance survey tool entitled Residents Assigned Appropriately to Certified Bed Audit Tool. These audits will be done weekly for four weeks and then monthly for three months or until substantial compliance is achieved. Quality Assurance The Administrator or designee will audit the coding of: Section N □ Antipsychotic, Anticoagulant and Opioid use; Section J-Falls with Major Injury of the Minimum Data Set Assessment using the quality assurance survey tool entitled Accurate Minimum Data Set Coding Audit Tool. (Attachment #14) The Administrator or designee will audit skilled nursing residents to ensure that they are assigned appropriately to Medicare/Medicaid certified beds using the quality assurance survey tool entitled Residents Assigned Appropriately to Certified Bed Audit Tool (Attachment #15). These audits will be done weekly for four weeks and then monthly for three months. Results will be reported weekly by the Administrator to the QA committee and corrective action initiated as appropriate. The QA committee is the main quality assurance committee. This regularly scheduled daily 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.	

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 _____	C 02/20/2020

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 641	Continued From page 18 The nursing home licensure & certification section approved a bed change request from the nursing home and issued a nursing home license effective 1/1/2020. The license indicated 30 adult care home beds in rooms 302, 304, 306, 308, 310 and rooms 401-410 effective 1/1/2020. An observation of room 406A on 2/17/20 at 11:25 AM revealed Resident #83 was residing in room 406A. On 2/18/20 at 9:35 AM the Administrator reported all the beds on the 400 hall were adult care home beds so Resident #83 was in an adult care home bed until yesterday when Resident #83 was moved to room 301. She indicated the resident should not have been admitted to the adult care home bed.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		3/13/20

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 _____	C 02/20/2020

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 656	Continued From page 19 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, family and staff interviews the facility failed to provide range of motion exercises in the right upper and lower extremities to reduce the risk of decline and failed to facilitate use of a communication tool as care planned for 1 of 18 residents reviewed for care plan implementation (Resident #16). The findings included: Resident #16 was admitted to the facility on 8/30/15 with diagnoses that included diabetes mellitus and hypothyroidism.	F 656	Corrective Action for Residents Affected On 03/06/20, the Minimum Data Set Nurse Consultant revised Resident #16□s care plan and CNA documentation tasks in Point of Care to reflect resident□s use of the provided communication board. On 03/04/20, the Administrator reviewed plan of care with resident□s RP to include range of motion exercises and communication board tasks. On 03/09/2020 the Rehab Director initiated a referral to our Therapy Maintenance Program which will replace this resident□s Restorative Nursing tasks.	

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 _____	C 02/20/2020

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 656	Continued From page 20 Resident #16's most recent Minimum Data Set (MDS) assessment dated 12/24/19 revealed he was assessed as moderately cognitively impaired by staff interview. He was assessed as having verbal behaviors towards others 1-3 days of the 7-day lookback period. Resident #16 was assessed as usually being understood and usually understands. He required extensive assistance with walking, dressing, toilet use, and bathing. Resident #16 required limited assistance with personal hygiene. Resident #16's Care Plan dated 1/7/20 revealed an intervention that read in part "I will perform 3 sets of 20 repetitions to right upper and lower extremities for at least 15 minutes per day, 3 days per week in order to minimize my risk for further decline in ROM (range of motion) to my right upper and lower extremities x 90 days." The care plan specified this being done by the restorative nurse aide or the nurse aide. Resident #16's Care Plan dated 1/7/20 revealed a second intervention that read in part "Ensure availability of communication board as supplied by ST (Speech Therapy)." The care plan specified this being done by the nurse aide. During an interview with Sitter #1 on 2/19/20 at 2:08 PM she stated she hadn't tried to utilize a communication board with Resident #16. She stated she had never seen him use it or any staff member use it with him. Sitter #1 stated she had not seen any of the nurse aides doing range of motion exercises with him. During an interview with Nurse Aide #2 on 2/19/20 at 2:15 PM she stated she did not provide any restorative nursing or range of motion exercises to any resident. She reported that she	F 656	Corrective Action for Resident Potentially Affected A 100% audit of all current residents□ care plans will be conducted to ensure that they accurately reflect their current status for restorative nursing programs. Any care plan identified as not accurately reflecting resident□s current restorative nursing program status will be revised and corrected immediately. This audit and any associated care plan revisions will be completed by the facility Minimum Data Set nurse and will be completed no later than 03/12/20. An additional audit will be conducted in order to review all current residents who have documented communication problems. All residents identified as having a communication problem will have a review of their care plan in order to validate whether or not it accurately reflects their current communication status and any communication strategies and/or assistive devices that are being used. Any current resident whose care plan does not accurately reflect their current communication status and use of any communication tools/strategies will immediately have a care plan revision so that these items may be added or removed. This audit and any associated care plan revisions will be completed by the facility Minimum Data Set nurse, and will be completed no later than 03/12/20. Systemic Changes On 03/05/20 the Regional Minimum Data	

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 _____	C 02/20/2020

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 656	Continued From page 21 believed these tasks were being completed by therapy staff. Nurse Aide #2 stated she was not Resident #16's regular aide but worked with him occasionally. The nurse aide added she worked on day shift. She had not seen Resident #16 use a communication board and had not been trained on its use. Nurse Aide #2 stated she had not seen any staff member attempted to use the communication board with Resident #16. An interview was conducted with the Rehabilitation Director on 2/19/20 at 2:36 PM. She stated therapy was not working with Resident #16. The Rehabilitation Director further stated that the restorative nursing program was closed on or about 1/1/20 and those tasks were to be completed by the assigned nurse aide for the resident. During an interview with Nurse Aide #3 on 2/20/20 at 10:24 AM she stated she did not provide any restorative nursing or range of motion exercises to Resident #16. She stated a restorative aide used to, but she did not work in restorative any longer. The nurse aide stated she worked with Resident #16 regularly on day shift. Nurse Aide #3 stated she has seen the Rehabilitation Director work with Resident #16. She further stated she received education about the communication board with Resident #16 but had not used it with him. An interview was conducted with Nurse Aide #4 on 2/20/20 at 10:53 AM who stated she had not done any restorative services with Resident #16. She stated she had not done restorative services with any of her residents. Nurse Aide #4 stated she has not provided any daily care for Resident #16 but had assisted other coworkers with some	F 656	Set Nurse Consultant provided in-service education to the facility Minimum Data Set Nurse on Comprehensive Care Plans. This education included the importance of ensuring that each resident□s care plan addressed actual problems, risk factors, resident strengths and preferences. The education emphasized that the care plan must communicate the resident□s current condition, needs, and preferences to the staff. Therefore, the care plan must have ongoing revisions and updates as the resident□s condition changes. Education also included the importance of ensuring that resident care plans are updated and accurately reflect any restorative nursing programs that they may be receiving; and that any resident identified as having difficulty communicating must have a care plan that reflects his/her current communication status; as well as any strategies or assistive devices that are utilized to enhance communication. Education included that care plans are used as a tool used to communicate resident□s condition, needs, preferences, strengths, and special needs to the interdisciplinary team and frontline staff; and that in order to provide the highest quality of care possible and to ensure residents□ needs are met, care plans must be person-centered and an accurate and current reflection of resident. This information has been integrated into the standard orientation training for new Minimum Data Set Nurses. In-service education began on 03/02/20 by the Administrator for all staff, including CNA□s and sitters. The in-service topics	

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 _____	C 02/20/2020

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 656	Continued From page 22 tasks. She stated she was unaware of any communication board. An interview was conducted with Sitter #2 on 2/20/20 at 11:22 AM. She stated she worked with Resident #16 individually. Sitter #2 stated she was unaware of him being care planned to use a communication board. She further stated she did not receive any training on the communication board. She indicated she had not seen any staff member do any range of motion exercises or use the communication board with Resident #16. During an interview with the Director of Nursing (DON) on 2/20/20 at 11:36 AM she stated that nurse aides should be completing restorative nursing with residents. She stated she was not aware that nurse aides were not completing these tasks. The DON further stated a mechanism for documenting these tasks would need to be implemented. She indicated nurse aides needed to make Resident #16's communication board available and document any refusals.	F 656	included: the purpose of care planning and areas that should be care planned; including Restorative Nursing Services and communication devices/tools. Education included reviewing Kardex information; CNA□s documenting these services under tasks in Point of Care, and reporting changes in condition and refusals to the nurse or MDS Coordinator. The Administrator will ensure that any employee who has not received this training by 03/09/2020 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff. Quality Assurance The Director of Nursing or designee will conduct audits to ensure that current residents have care plans that accurately reflect their current status regarding Restorative Nursing Services and Communication Problems, including use of Communication Assistive Devices/Strategies. The Quality Assurance tool entitled Comprehensive Care Plans QA Tool will be completed weekly for four weeks then monthly for three months or until sustained compliance has been achieved. 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 regularly scheduled daily meeting is attended by the Administrator, Director of Nursing/MDS Coordinator, and Social Services Coordinator/Activity Director, and	

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 _____	C 02/20/2020

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 656	Continued From page 23	F 656	Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		3/13/20

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 _____	C 02/20/2020

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 690	Continued From page 24 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to prevent a urinary catheter bag from being in contact with the floor for 1 (Resident #20) of 1 resident reviewed for urinary catheter care. The finding included: Resident # 20 was admitted to the facility on 10/22/18 with diagnoses which included dementia, atrial fibrillation and neuromuscular dysfunction of the bladder. The quarterly Minimum Data Set (MDS) dated 1/4/20 revealed Resident #20 was severely cognitively impaired. He required extensive to total assistance with activities of daily living. He had an indwelling catheter and was incontinent of bowel. The care plan dated 1/24/20 addressed Resident #20 had an indwelling catheter related to neurogenic bladder. An observation on 2/17/20 at 3:34 PM revealed Resident #20 was in bed and the Resident's urinary catheter drainage bag was attached to the left side of the bed near the foot of the bed. The urinary catheter drainage bag was visible from the doorway to Resident #20's room. The urinary catheter drainage bag was touching the floor. An observation on 2/18/20 at 2:03 PM revealed Resident #20 was in bed and the Resident's urinary catheter drainage bag was touching the	F 690	Corrective Action for Residents Affected Resident #20 catheter drainage bag was adjusted to hang at the proper height on 2/18/20 by the nurse. On 03/07/20, the MDS Coordinator added a task for CNA□s in Point of Care and Nurses on the Treatment Administration Record to verify that catheter bag is not touching the floor and in proper alignment to fire every shift. Corrective Action for Resident Potentially Affected All other catheters were audited on 2/18/20 to ensure they were not touching the floor. No other concerns identified for 5 of 5 residents. On 03/06/20, the MDS Coordinator added a task for CNA□s in Point of Care and Nurses in the Treatment Administration Record to verify that catheter bag is not touching the floor and in proper alignment to fire every shift. Systemic Changes In-service education began on 03/02/20 by the Administrator for the Nursing Department. The in-service topics included: Liberty□s Policy for Catheter Care. The Administrator will ensure that any employee who has not received this training by 03/09/2020 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff. When new admissions or current	

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 _____	C 02/20/2020

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 690	Continued From page 25 floor with ¼ of the bag on the floor. On 2/18/20 at 2:10 PM Nursing Assistant (NA) #1 stated she provided care to Resident #20 during the 7:00 AM to 3:00 PM shift on 2/18/20. NA #1 observed the Resident's urinary catheter drainage bag was touching the floor. She stated the urinary catheter drainage bag should not be touching or laying on the floor and she needed to move the urinary catheter drainage bag off the floor. On 2/18/20 at 2:19 PM Nurse #1 stated she flushed Resident #20's urinary catheter during the morning medication pass on 2/18/20 at approximately 9:45 AM. She stated his urinary catheter drainage bag was not on the floor at that time. She said the Resident's bed must have been lowered which caused the urinary catheter bag to be on the floor. She stated the urinary catheter bag should not touch the floor and she would ask the NA to correct it. The Director on Nursing (DON) was interviewed on 2/18/20 at 2:29 PM. The DON stated the Resident's urinary catheter drainage bag should not touch the floor because it was an infection control concern. On 2/19/20 at 4:28 PM Resident #20 was observed in bed. His urinary catheter drainage bag was laying completely on the floor under his bed. This was observed from the entrance doorway into Resident #20 room. On 2/19/20 at 4:30 PM the DON observed Resident #20's urinary catheter drainage bag was laying on the floor under his bed. She stated the urinary catheter bag should not be on the floor	F 690	residents receive foley catheters, the MDS Coordinator will initiate a task for CNA□s in Point of Care and Nurses in the Treatment Administration Record to verify that catheter bag is not touching the floor and in proper alignment to fire every shift. Quality Assurance The Director of Nursing will monitor this through the QA Tool for Monitoring Catheter Bag Placement. The Director of Nursing will monitor all residents with catheters 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 regularly scheduled daily 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.	

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 _____	C 02/20/2020

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 690	Continued From page 26 and she and Nurse #2 would complete urinary catheter care and replace the urinary catheter bag.	F 690		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to keep unattended medications in a secured treatment cart for 1 of 1 treatment cart observed.	F 761	Corrective Action for Residents Affected The treatment cart was locked on 2/17/20 by the nurse. Corrective Action for Resident Potentially	3/13/20

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 _____	C 02/20/2020

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 761	Continued From page 27 Findings included: During observation on 2/17/20 at 11:00 AM, the treatment cart was observed unlocked and unattended. The treatment cart was observed in the unlocked position. At 11:00 AM, 2 residents were observed sitting in the hall near the treatment cart. At 11:02 AM 2 residents were observed to self-propel in wheelchairs down hall past the unlocked treatment cart. At 11:03 AM 2 housekeeping aides walked by the unlocked treatment cart. At 11:05 AM Nurse #4 walked past the unlocked treatment cart. At 11:06 AM Nurse #3 walked by the unlocked treatment cart. During an interview on 2/17/20 at 11:07 AM, Nurse #4 stated the treatment cart should have been locked because it was left unattended in the hall. She stated Nurse #3 was the nurse who had been doing treatments and must have left the cart unlocked. During an interview on 2/17/20 at 11:09 AM, Nurse #3 confirmed she was responsible for the treatment cart and she was unaware it had been left unlocked. She stated she did not know how long it had been left unattended and unlocked but it should have been locked. Observation of the treatment cart on 2/19/20 at 12:00 PM revealed it included: Santyl, Triple Antibiotic Ointment, Antifungal powder, Nystatin, Lidocaine, and Voltaren gel as well as various over-the-counter creams. During an interview on 2/19/20 at 1:31 PM, the Director of Nursing (DON) stated medication carts and treatment carts should be locked when unattended.	F 761	Affected The treatment cart will remain locked when not in use. Systemic Changes In-service education began on 03/02/20 by the Administrator for all staff. The in-service topics included: Liberty□s Use of the Treatment Cart Policy, including instructions that any staff who note an unlocked and unattended cart are to lock it immediately. The Administrator will ensure that any employee who has not received this training by 03/09/2020 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff. Quality Assurance The Nursing Secretary will monitor this through the QA Tool for Monitoring Cart Locking. The Nursing Secretary will observe all medication and treatment carts with this tool weekly for four weeks, and monthly for three months, or until resolved by the QA committee. Any corrective action will be taken immediately to ensure the carts are locked. 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 regularly scheduled daily 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	

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 _____	C 02/20/2020

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 761	Continued From page 28 During an interview on 2/19/20 at 2:45 PM, the Administrator stated the staff should have kept the treatment carts locked when unattended and she did not know why they had not done so.	F 761	Meeting.	
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		3/13/20

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 _____	C 02/20/2020

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 883	Continued From page 29 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to assess the residents for eligibility and ensure residents were offered the pneumococcal vaccine for 5 of 5 residents reviewed for immunizations (Resident #13, #14, #16, #17, and #25). Findings included: The facility policy for Pneumococcal Immunization with the effective date of 4/2011 stated in part "For annual resident vaccinations it is the policy of this facility to vaccinate all residents against pneumococcal disease and influenza unless refused or contraindicated." The	F 883	Corrective Action for Residents Affected Residents #13, #14, #16, #17, #25 were offered pneumonia vaccines between 02/24/20 and 03/08/20 and if the resident and/or RP consented, the immunizations were administered during that time by the nurse and documented them under the Immunization Tab in Point Click Care. Corrective Action for Resident Potentially Affected All residents have the potential to be affected by the alleged deficient practice. All residents were offered pneumonia vaccines between 02/24/20 and 03/08/20	

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 _____	C 02/20/2020

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 883	Continued From page 30	F 883		

facility policy further stated in part "follow the guidelines for administering Pneumococcal Vaccines Pneumococcal conjugate vaccine 13 (PCV13) and Pneumococcal polysaccharide vaccine (PPSV 23)".

1. Resident #13 was admitted to the facility on 8/30/19 with reentry on 11/12/19 with diagnoses which included diabetes mellitus and congestive heart failure.

Review of the most recent Minimum Data Set (MDS) dated 12/13/19 indicated Resident #13 was cognitively intact and the pneumococcal vaccine section was coded to indicate the vaccine was not up to date and had not been offered.

Review of immunization record for Resident #13 revealed no PCV13 or PPSV23 had been documented as administered or refused.

An interview with the Director of Nursing (DON) on 2/18/20 at 2:47 PM revealed she had assumed the Infection Control position the day before and was unaware that the residents' pneumococcal vaccines had not been completed as they should have been. She stated all residents should be offered the pneumococcal vaccines (PCV13 and PPSV23) and had no documentation to determine if this had been done for Resident #13. She stated she did not know why the pneumococcal vaccines had not been offered or given.

An interview with the Administrator on 2/19/20 at 10:47 AM revealed she was unaware that the residents were not being offered or given both the PCV13 and PPSV23. She further stated the facility should have followed the policy and

and if the resident and/or RP consented; the immunizations were administered during that time. Pneumonia Immunizations were 100% up to date by 03/08/20.

Systemic Changes
In-service education began on 03/02/20 by the Administrator for all nurses. The in-service topics included: Liberty□s Standing Orders for Administering Pneumococcal Vaccines, including documenting receipt or declination of Pneumonia Vaccines under the Immunizations Tab in Point Click Care. The Administrator will ensure that any employee who has not received this training by 03/09/2020 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training for all staff.

Quality Assurance
The Administrator or Director of Nursing will monitor this through the Immunization Audit Tool. The Administrator or Director of Nursing will monitor five residents□ immunization status with this tool; and corrective action taken as appropriate, 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 regularly scheduled daily meeting is attended by the Administrator, Director of

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 _____	C 02/20/2020

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 883	Continued From page 31 offered both pneumococcal vaccines to all residents. 2. Resident #14 was admitted to the facility on 7/08/11 with reentry on 4/20/15 with diagnoses which included diabetes mellitus, congestive heart failure, and chronic obstructive pulmonary disease. Review of the most recent Minimum Data Set (MDS) dated 12/13/19 indicated Resident #14 had severe cognitive impairment and the pneumococcal vaccine section was coded to indicate the vaccine was not up to date and had not been offered. Review of immunization record for Resident #14 revealed no PPSV23 had been documented as administered or refused. An interview with the Director of Nursing (DON) on 2/18/20 at 2:47 PM revealed she had assumed the Infection Control position the day before and was unaware that the residents' pneumococcal vaccines had not been completed as they should have been. She stated all residents should be offered the pneumococcal vaccines (PCV13 and PPSV23) and had no documentation to determine if this had been done for Resident #14. She stated she did not know why the pneumococcal vaccines had not been offered or given. An interview with the Administrator on 2/19/20 at 10:47 AM revealed she was unaware that the residents were not being offered or given both the PCV13 and PPSV23. She further stated the facility should have followed the policy and offered both pneumococcal vaccines to all	F 883	Nursing/MDS Coordinator, and Social Services Coordinator/Activity Director, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	

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 _____	C 02/20/2020

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 883	Continued From page 32	F 883		

residents.

3. Resident #16 was admitted to the facility on 8/3/15 with reentry on 6/2/18 with diagnoses which included diabetes mellitus and coronary artery disease.

Review of the most recent Minimum Data Set (MDS) dated 12/24/19 indicated Resident #16 had moderate impaired cognition and the pneumococcal vaccine section was coded to indicate the vaccine was not up to date and had not been offered.

Review of immunization record for Resident #16 revealed no PPSV23 had been documented as administered or refused.

An interview with the Director of Nursing (DON) on 2/18/20 at 2:47 PM revealed she had assumed the Infection Control position the day before and was unaware that the residents' pneumococcal vaccines had not been completed as they should have been. She stated all residents should be offered the pneumococcal vaccines (PCV13 and PPSV23) and had no documentation to determine if this had been done for Resident #16. She stated she did not know why the pneumococcal vaccines had not been offered or given.

An interview with the Administrator on 2/19/20 at 10:47 AM revealed she was unaware that the residents were not being offered or given both the PCV13 and PPSV23. She further stated the facility should have followed the policy and offered both pneumococcal vaccines to all residents.

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 _____	C 02/20/2020

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 883	Continued From page 33	F 883		

4. Resident #17 was admitted to the facility on 10/05/17 with diagnoses which included multiple sclerosis and anxiety.

Review of the most recent Minimum Data Set (MDS) dated 12/29/19 indicated Resident #17 was cognitively intact and the pneumococcal vaccine section was coded to indicate the vaccine was not up to date and had not been offered.

Review of immunization record for Resident #17 revealed no PPSV23 had been documented as administered or refused.

An interview with the Director of Nursing (DON) on 2/18/20 at 2:47 PM revealed she had assumed the Infection Control position the day before and was unaware that the residents' pneumococcal vaccines had not been completed as they should have been. She stated all residents should be offered the pneumococcal vaccines (PCV13 and PPSV23) and had no documentation to determine if this had been done for Resident #17. She stated she did not know why the pneumococcal vaccines had not been offered or given.

An interview with the Administrator on 2/19/20 at 10:47 AM revealed she was unaware that the residents were not being offered or given both the PCV13 and PPSV23. She further stated the facility should have followed the policy and offered both pneumococcal vaccines to all residents.

5. Resident #25 was admitted to the facility on 7/22/16 with reentry on 9/18/18 with diagnoses which included syringomyelia (central cavitation of the spinal cord) and syringobulbia (cavitation of

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 _____	C 02/20/2020

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 883	Continued From page 34	F 883		

the medulla).

Review of the most recent Minimum Data Set (MDS) dated 1/10/20 indicated Resident #25 was cognitively intact and the pneumococcal vaccine section was coded to indicate the vaccine was not up to date and had been offered and declined.

Review of immunization record for Resident #25 revealed no PPSV23 had been documented as administered or refused.

An interview with the Director of Nursing (DON) on 2/18/20 at 2:47 PM revealed she had assumed the Infection Control position the day before and was unaware that the residents' pneumococcal vaccines had not been completed as they should have been. She stated all residents should be offered the pneumococcal vaccines (PCV13 and PPSV23) and had no documentation to determine if PPSV23 had been offered or given for Resident #25. She stated she did not know why the PPSV23 had not been offered or given to Resident #25.

An interview with the Administrator on 2/19/20 at 10:47 AM revealed she was unaware that the residents were not being offered or given both the PCV13 and PPSV23. She further stated the facility should have followed the policy and offered both pneumococcal vaccines to all residents.