PRINTED: 02/18/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		345407	B. WING		C 01/15/2021
NAME OF PROVIDER OR SUPPLIER  CROSS CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 QUARTER ROAD SWANQUARTER, NC 27885	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLETION
F 000	INITIAL COMMENTS	8	F 00	00	
		ation survey was conducted h 1/15/21. Event ID#			
	substantiated resultine F677, and F690.	laint allegation(s) was/were ng in deficiencies F550,			
F 550 SS=D	Resident Rights/Exe CFR(s): 483.10(a)(1		F 55	60	1/29/21
	self-determination, a access to persons a	Rights. ight to a dignified existence, nd communication with and nd services inside and ncluding those specified in			
	with respect and digresident in a manner promotes maintenanther quality of life, rec	ity must treat each resident nity and care for each and in an environment that ace or enhancement of his or cognizing each resident's illity must protect and f the resident.			
	access to quality car severity of condition, must establish and n practices regarding t	acility must provide equal re regardless of diagnosis, or payment source. A facility naintain identical policies and transfer, discharge, and the under the State plan for all of payment source.			
		right to exercise his or her of the facility and as a citizen			
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE .	TITLE	(X6) DATE

Electronically Signed 01/29/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	resident can exercise interference, coercior from the facility.  §483.10(b)(2) The refree of interference, coreprisal from the facility rights and to be supplexercise of his or her subpart.  This REQUIREMENT by:  Based on record revinterviews, the facility dignity by waking upprovide showers during out of 3 residents reviet).  The findings included Resident #6 was adm 10/15/17 with diagnoral disorder, depression,  Resident #6's Annual with an Assessment F8/16/20 indicated the intact and required places as a control of the shower of the shower review	cility must ensure that the his or her rights without and discrimination, or reprisal sident has the right to be decercion, discrimination, and dity in exercising his or her corted by the facility in the rights as required under this is not met as evidenced diews and staff and resident are residents to offer and and normal sleep hours for 1 diewed for dignity (Resident diewed for dignity (Resident diewest that included anxiety and insomnia.  Minimum Data Set (MDS) Review Date (ARD) of resident was cognitively any sical assistance of 1 diexercity experience of 1 diexercity experienc	F 55	The statements made on this plan or correction are not an admission to ar not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or we take the actions set forth in this plan 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 Affect Patient #6 shower was adjusted to not later than 9 PM per her request on 1/15/21.  Corrective Action: for Resident Poter Affected. 100% interviewable resider were evaluated for shower schedule preferences on 1/21/21 by the Direct Nursing and adjustments made as needed.	eted:

NAME OF PROVIDER OR SUPPLIER  CROSS CREEK HEALTH CARE    MINING   STREET ADDRESS, CITY, STATE, 2IP CODE   1/19 QUARTER RAD	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
ROBS CREEK HEALTH CARE    1719 QUARTER NO. 27885   1710 QUARTER NO. 278			345407	B. WING _	B. WING			1	
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FREETIX TAG  FREGULATORY OR LSC.IDENTIFYING INFORMATION)  F 550  Continued From page 2  A nursing progress note dated 10/24/20 at 2:32  AM, written by Nurse #2, revealed Resident #6 refused a shower and bed bath, because she was too tired.  A nursing progress note dated 12/1/20 at 11:15  PM, written by Nurse #2, indicated the Resident #6 refused a shower and a bed bath was given.  During an interview with Resident #6 or 1/12/21 at 1:40PM she revealed that her preferred time to receive a shower was during the evening before she went to bed. The resident specified that her preferred bedtime was 10:00PM. Resident #6 further stated during the month of December, she was awoken by staff at 1:00 AM to be provided a shower. She further revealed this had upset her to be awoken by staff to receive a shower at night. Resident #6 stated after her shower she had to return to bed with a wet head.  During an interview on 1/12/21 at 4:50PM, with MedTech #1 who worked the 7:00PM to 7:00AM shift, it was revealed that residents and showers for all the residents across the facility.  An interview on 1/12/21 at 5:11PM with NA #3 who worked the 7:00PM - 7:00AM shift, revealed resident bed baths were given before showers. NA#3 further stated cursing har Point Click Care EMR, Dashboard and via general observation/interviews on rounds. These audits will be done weekly for four weeks and then monthly for three months.  Cuality Assurance: The Administrator or Director of Nursing will audit residents to ensure the shower schedule is followed using Point Click Care EMR, Dashboard and via general observation/interviews on rounds. These audits will be done weekly for four weeks and then monthly for three months.  Cuality Assurance: The Administrator or Director of Nursing will audit residents to ensure the shower schedule is followed using Point Click Care EMR, Dashboard and via general observation/interviews on rounds. These audits will be done weekly for four weeks and then monthly for three months.  Cuality Assurance: The Administrator to	040.15	CLIMMADY	TATEMENT OF DEFICIENCIES			T		0(5)	
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facility.  attended by the Administrator, Director of Nursing/MDS Coordinator, and Social Services Coordinator/Activity Director, and who worked the 7:00PM - 7:00AM shift, revealed resident bed baths were given before showers.  NA#3 further stated resident showers were  attended by the Administrator, Director of Nursing/MDS Coordinator, and Services Coordinator/Activity Director, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.		,	· · ·				IIS		
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resident bed baths were given before showers.  NA#3 further stated resident showers were  will review during the Quarterly QA  Meeting.						_			
NA#3 further stated resident showers were Meeting.		,							
			<del>-</del>			_			
The NA#4, who worked the 7:00PM - 7:00AM									
shift, was interviewed on 1/12/21 at 5:30PM. NA									
#4 stated that resident bed baths were given before showers. NA#4 further stated resident			· ·						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345407	B. WING			C / <b>15/2021</b>
NAME OF PROVIDER OR SUPPLIER  CROSS CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 QUARTER ROAD SWANQUARTER, NC 27885	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677 SS=D	resident showers follot there were only 2 NA She indicated resider by staff to receive the An interview with the 3:48PM, she revealed concerns voiced by respective she stated resident shower stated resident shower preferent and the facility's process upon admission, resident shower preferent receive a shower.  ADL Care Provided for CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident and oral hydronial and oral hydronial respective shower preferent activities of daily be serviced to maintain a personal and oral hydronial residents (Figure 1).	mpleted by staff until ed it took that long to provide owing bed baths - because is working on the night shift. Into were woken up at night ir showers.  Administrator on 1/14/21 at d she had not received any esidents regarding showers. howers should be 1.  With the Administrator on ishe stated residents should taff for showers, that was edure. She further stated, dents were interviewed for ice and preferred time to  or Dependent Residents  ent who is unable to carry iving receives the necessary good nutrition, grooming, and giene; is not met as evidenced  ons, record review, and staff failed to provide nail care desident #3) who were staff for activities of daily	F	Corrective Action for Residents Affect Resident #3 Nails were trimmed and cleaned on 1/15/21 when resident finagreed.  Corrective Action for Resident Potent Affected. 100% of resident nails were cleaned and trimmed by nursing staff 1/12/21 as needed.	ally	1/29/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		0.45407			С
		345407	B. WING		01/15/2021
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
CROSS C	REEK HEALTH CARE			1719 QUARTER ROAD	
OKOOO O	KLEK HEALIH OAKE			SWANQUARTER, NC 27885	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION)  ID PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  TAG CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)		D BE COMPLETION	
F 677	diagnoses which including diagnoses which including the provided Residual of the provided Residu	tent reentry on 11/17/20 with uded cerebral palsy.  Im Data Set (MDS) dated esident #3 was cognitively with return anticipated MDS ated Resident #3 extensive ties of daily living except he n eating.  In 2/21 at 11:16 AM with esident #3 had severe mands and visualization of d. The fingernails visualized is and left little finger nail.  I left little finger nail were debris was observed under with Nurse #1 on 1/12/21 at	F 67	Systemic Changes Nail care has bee assigned to the licensed staff on the Treatment Administration Record in Click every two weeks (weekly for residents diagnosed with Diabetes). Administrator or Director of Nursing audit residents to ensure that nail ca has been completed as assigned usi the Point Click Care Electronic Medic Record, Treatment Administration se and general observations. These audit will be done weekly for four weeks at then monthly for three months.  Quality Assurance The Administrator Director of Nursing will audit resident ensure that nail care has been comp as assigned using Point Click Care Electronic Medical Record, Treatmer Administration record and general observations. These audits will be dweekly for four weeks and then mont for three months. Results will be represented to the Quality of the Administrator to the Quality by the Administrator to the Quality by the Administrator to the Quality and the province and corrective action initial committee and corrective action initial.	Point The will re ng cal ction dits nd or sto leted at they corted A ated
F 690 SS=D	1/12/21 at 12:15 PM s fingernails were too k under them. She also why the resident's na cleaned, but that he s	with the Administrator on she stated Resident #3's ong and had brown debris stated she did not know ils had not been cut and should have had nail care.  inence, Catheter, UTI -(3)	F 69	as appropriate. The QA committee is main quality assurance committee. regularly scheduled daily meeting is attended by the Administrator, Direct Nursing/MDS Coordinator, and Socia Services Coordinator/Activity Directo Dietary Manager. The Medical Direct will review during the Quarterly QA Meeting.	This or of al r, and

PRINTED: 02/18/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
345407		B. WING		C 01/15/2021		
NAME OF PROVIDER OR SUPPLIER  CROSS CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1719 QUARTER ROAD SWANQUARTER, NC 27885	3 11 10 20 2 1		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 690	admission receives similarity maintain continence to condition is or become not possible to maintain \$483.25(e)(2)For a reincontinence, based of comprehensive assessment that— (i) A resident who entindwelling catheter is resident's clinical concatheterization was note (ii) A resident who entindwelling catheter or is assessed for removas possible unless the demonstrates that catheterization who is receives appropriate prevent urinary tract in continence to the extension of the e	cility must ensure that tent of bladder and bowel on tervices and assistance to unless his or her clinical tes such that continence is ain.  Issident with urinary on the resident's terment, the facility must ters the facility without an not catheterized unless the dition demonstrates that tecessary; ters the facility with an subsequently receives one resident's clinical condition the terization is necessary; the treatment and services to infections and to restore tent possible.  The sident with fecal on the resident's the who is incontinent of bowel treatment and services to all bowel function as  This is not met as evidenced This, record review, and staff	F 690	Corrective Action for Residents Affecte Indwelling catheter stabilizers were	ed	
		heter tubing for 2 of 3		applied to Resident 3 and resident #7	on	

Facility ID: 943128

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	345407		B. WING		0.1	C 01/15/2021	
NAME OF P	ROVIDER OR SUPPLIER	0.0.0.	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>    U   U   U   U   U   U   U   U   U  </u>	1/15/2021	
10 001	TO VIDER ON GOI'T EIER			1719 QUARTER ROAD			
CROSS C	REEK HEALTH CARE			SWANQUARTER, NC 27885			
(X4) ID			ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	COMPLETION DATE	
F 690	Continued From page	e 6	F 69	0			
	residents (Resident # reviewed for urinary of	•		1/12/21.			
	Findings included:			Corrective Action for Resident Po Affected. All residents with Induc catheters were assessed and sta	elling		
	1. Resident #3 was a	dmitted to the facility on		were applied as needed by nurs			
	1/13/18 with most red diagnoses which include	ent reentry on 11/17/20 with uded cerebral palsy.		(One resident refused) on 1/12/2 Systemic Changes Indwelling Ca	21.		
	8/5/20/20 indicated R intact. The Discharge dated 10/31/20 indica assistance with activi was independent with	The quarterly Minimum Data Set (MDS) dated 8/5/20/20 indicated Resident #3 was cognitively intact. The Discharge with return anticipated MDS dated 10/31/20 indicated Resident #3 extensive assistance with activities of daily living except he was independent with eating and was coded for an indwelling catheter.		Stabilizers have been assigned to licensed staff on the Treatment Administration Record in Point Conshift. The Administrator or Direct Nursing will audit residents to en they have indwelling catheter staplace each shift using the Point Collectronic Medical Record, Trea	to the click every or of sure that abilizers in Click Care		
		12/21 at 11:16 AM with		Administration section. These a			
		esident #3 had an indwelling no catheter tube securement		be done weekly for four weeks a monthly for three months.	nd then		
				Quality Assurance The Administr	ator or		
	#1 on 1/12/21 at 12:5 nurses were responsi who have an indwelling	with Nursing Assistant (NA) 9 PM she revealed the ble to ensure the residents and urinary catheter had a leg aurement device in place to be the resident's leg.		Director of Nursing will audit resi ensure that they have indwelling stabilizers in place each shift usi Click Care Electronic Medical Re Treatment Administration record audits will be done weekly for for and then monthly for three mont	catheter ng Point ecord, I. These ur weeks		
	During an interview w	rith Nurse #1 on 1/12/21 at		Results will be reported weekly be			
	1:08 PM she revealed			Administrator to the QA committee	•		
		the resident had a catheter		corrective action initiated as app			
	•	nd she did not know why		The QA committee is the main q	•		
	Resident #3 did not h	<del>_</del>		assurance committee. This regulation scheduled daily meeting is atten	ılarly		
	During an interview w	rith the Administrator on		the Administrator, Director of	-		
	_	she stated Resident #3		Nursing/MDS Coordinator, and S	Social		
		theter securement device why he did not have one in		Services Coordinator/Activity Dir Dietary Manager. The Medical I			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	<b>345407</b> B.		B. WING			C 01/15/2021	
NAME OF PROVIDER OR SUPPLIER  CROSS CREEK HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE  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)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ORRECTION ON SHOULD BE IE APPROPRIATE ()	(X5) COMPLETION DATE	
F 690	place.  2. Resident #7 was a 6/11/19 with most rediagnoses which incl The quarterly Minimum 11/10/20 indicated R intact and was coded An observation on 1/Resident #7 had an inwith no catheter tube secure the catheter to buring an interview #1 on 1/12/21 at 12:5 nurses were responsively who have indwelling adhesive securement Resident #7 usually not know why he did During an interview who have individually not know why he did During an interview who have individually not know why he did During an interview who have individually not know why he did During an interview who have individually not know why he did During an interview who have individually not know why he did During an interview who have an interview who have had a cather who had a cather w	admitted to the facility on cent reentry on 8/03/20 with uded neurogenic bladder.  Im Data Set (MDS) dated esident #3 was cognitively a for an indwelling catheter.  12/21 at 10:55 AM revealed indwelling urinary catheter esecurement device to on the resident's leg.  with Nursing Assistant (NA) 59 PM she revealed the sible to ensure the residents urinary had a leg strap or at device. She also stated thad a leg strap and she did not have it in place.  with Nurse #1 on 1/12/21 at did the nurses were es the resident had a catheter and she did not know why	F 69	will review during the Quarte Meeting.	erly QA		