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F 000	INITIAL COMMENTS A complaint survey was conducted from 03/23/21 through 3/29/21. Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J The tag F600 constituted Substandard Quality of Care. A partial extended survey was conducted. 2 of the 3 complaint allegations were substantiated resulting in deficiency.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff and the Medical Director the facility failed to complete a competency skills check for 1 of 7 nursing	F 600	Past noncompliance: no plan of correction required.	4/8/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/09/2021

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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assistants (Nursing Assistant #1), failed to use a mechanical lift for transfers as specified in the care plan, failed to use 2 staff when providing care, failed to report a fall to the nurse and failed to have a nurse assess a resident after a fall for 1 (Resident #1) of 3 residents reviewed for falls. Resident #1 sustained a right distal femur fracture when she fell from the bed while care was being provided by one staff member (NA #1) and the resident required a narcotic pain medication.

The findings included:

Resident #1 was admitted to the facility on 2/27/19 with diagnoses that included dementia and contractures of both knees.

Review of Resident #1's quarterly Minimum Data Set assessment, dated 7/6/2020 revealed she was assessed as severely cognitively impaired. The assessment revealed Resident #1 required extensive assistance of two or more people for bed mobility and transfers. She was assessed as totally dependent with the assistance of two people for dressing and toilet use.

Resident #1's care plan reviewed on 7/9/20 revealed she was care planned for increased risk for falls. The interventions included a low bed with a fall mat, check frequently throughout shift and anticipate needs as much as possible. The care plan also identified Activities of Daily Living selfcare performance deficit related to dementia and limited mobility. The interventions for this included requires extensive assistance to reposition and turn in bed. Another intervention revealed she required total assistance using a total mechanical lift for transfers (green sling) and

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to assist resident to her wheelchair prior to meals.

A nursing progress note written by Nurse #1 dated 9/14/20 at 9:22 PM read in part, "Aide reported to nurse that resident had area of edema above right knee. Area of edema not warm to touch but has pain when palpated. Area was around 30cm (centimeters) diameter." The doctor ordered pain medication to be given as needed and for an x-ray to be completed the next morning.

On 9/15/20 at 6:10 AM Nurse #1 completed a change in condition form which revealed Resident #1 had functional decline, acute pain in her right knee with swelling from the right knee to the hip joint. The note indicated the swollen area had increased in size.

An additional note by Nurse #1 written on 9/16/20 as a late entry for 9/15/20 at 6:34 AM revealed Resident #1 was laying on her right side and the swollen area had now spread from the right knee area up to the right thigh area. The area was slightly warmer than the other leg and was painful to touch. She notified the practitioner at 6:11 AM and Resident #1 was sent to the emergency room by ambulance for further examination.

A late entry progress note by the Director of Nursing (DON) revealed on 9/15/20 at 8:25 AM Nurse #2 was notified Resident #1 was assisted, by sliding down the NA's (Nursing Assistant) leg, onto the fall mat while the resident was in the bed being changed on 9/14/20. The note revealed NA #1 said "Resident was aided to the floor so she wouldn't fall." Once on the floor NA #1 got NA #2 and Resident #1 was picked up and put back into her wheelchair. NA #1 said Resident #1 did not

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say she was hurt, and Resident #1 propelled herself in the wheelchair to her table. The note read Resident #1 was assessed by Nurse #1 and the Physician was notified. Orders were received to obtain an x-ray in the morning as well as to monitor the leg and if condition worsens to send resident to the Emergency Department for an evaluation. The note documented the resident was sent to the Emergency Department.

Review of emergency department (ED) notes dated 9/15/20 revealed Resident #1 was seen at 8:16 AM with the complaint of swollen right knee with pain that was travelling up the thigh. An x-ray was completed and diagnosed her with a distal femur fracture. Resident #1 was determined not to be a candidate for surgery and a bulky dressing was applied to inhibit motion at the knee. She was discharged back to the facility at 4:14 PM with instructions to follow-up with orthopedics. The notes also revealed Resident #1 had an order for Norco (narcotic pain medication) prior to ED visit and was discharged with an order for the same medication to be given as 1 tablet every 6 hours as needed for pain.

An interview was conducted with NA #3 on 3/23/21 at 2:37 PM who stated she was familiar with Resident #1's care. She reported she worked in the facility for over a year and Resident #1 had always required two people to perform incontinence care and transfers. NA #3 stated all mechanical lift transfers required two staff members.

An interview was conducted with NA #2 on 3/23/21 at 2:45 PM who stated she was approached by NA #1 at approximately 6:30 PM on 9/14/20 requesting assistance. She stated NA

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F 600	Continued From page 4 #1 told her it was important and could not wait. NA #2 stated when she entered Resident #1's room Resident #1 was on the floor partially on the fall mat. She reported that NA #1 requested her assistance to place Resident #1 into her wheelchair. NA #2 reported she and NA #1 lifted Resident #1 back in her wheelchair without using the mechanical lift. She stated Resident #1 denied any pain and propelled herself to the other side of her room. NA #2 stated she did not report the incident because she believed NA #1 had already reported the fall to the nurse. She further reported she had questioned NA #1 about using a mechanical lift or a draw sheet to get Resident #1 off the floor and NA #1 stated it was not necessary. NA #2 added Resident #1 required two people to perform incontinence care and transfers. She was unable to articulate why she assisted in the transfer of Resident #1 without a mechanical lift. An interview was conducted with NA #1 on 3/24/21 at 9:44 AM. NA #1 reported she was working the 7:00 AM to 7:00 PM shift on 9/14/20 and when she was completing the end of her shift rounds, she noticed Resident #1 required incontinence care. NA #1 said she transferred Resident #1 onto her bed to perform care. She stated she placed her wheelchair close to the bed and she moved Resident #1 by lifting her by her shoulder and her pants. At the end of the care NA #1 reported she was putting the resident ' s pants back on when Resident #1 began squirming and grabbed at her. NA #1 then said she turned Resident #1 towards her and Resident #1 ' s legs fell off the bed. NA #1 said she assisted Resident #1 to the floor, but she was unable to get the resident back into her wheelchair. NA #1 stated she went to the door	F 600		

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F 600	Continued From page 5 and saw NA #2. She reported she asked NA #2 for assistance. NA #1 stated NA #2 was able to lift Resident #1 to the wheelchair without her assistance. NA #1 stated she was not trained how to use the total mechanical lift and was not aware Resident #1 required a total mechanical lift for transfers. She stated she learned about Resident #1's care requirements by asking other staff and through observation. NA #1 reported she had not worked with a resident in the facility who required the use of a total mechanical lift. She stated she had provided care to Resident #1 previously but had not used a lift. NA #1 further stated she would transfer Resident #1 by lifting her by her shoulder and her pants. She stated she did not require assistance of another staff member. NA #1 revealed Resident #1 was included on the paper on a bulletin board in the nursing station as requiring a total mechanical lift for transfers, but she was not aware of this list until after the incident. She stated that she did not receive training about providing care for Resident #1 but stated she should have asked more questions. NA #1 stated she informed Nurse #2 about the incident the next day on 9/15/20. She said that upon entering the building for work on 9/15/20 she noticed the ambulance and asked who the resident was. NA #1 stated when she was told it was Resident #1, she then told Nurse #2 about what happened the previous evening. She said she did not report the incident to the nurse on 9/14/20 because she did not consider it as a fall. The nurse aide added that since she let the resident travel down her body to the mat, she did not consider it a fall. She reported when discussing the issue with the Administrator, the Administrator informed NA #1 that the incident was classified as a fall.	F 600		

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F 600	Continued From page 6 An interview was conducted with Nurse #2 on 3/23/21 at 3:01 PM. She stated she remembered on the morning of 9/15/20 NA #1 informed her of the incident. Nurse #2 stated she was not informed at the time that the incident occurred on 9/14/20. She stated she was unable to recall any additional details. A review of the facility's fall investigation revealed NA #6 and NA #7 were the 2 staff who worked on the 7:00 PM to 7:00 AM shift on 9/14/20. They both worked with Resident #1. Attempts to contact NA #6 and NA #7 were unsuccessful. An interview was conducted with Nurse #1 on 3/24/21 at 4:05 PM. She stated she had assessed Resident #1 on the evening of 9/14/20 after she was advised by the nurse assistants that her leg was swollen. She said she did not remember which NA was working that night but they both reported the leg swelling to her. Nurse #1 stated she reassessed Resident #1 on the morning of 9/15/20. The nurse reported Resident #1's right lower leg was swollen and was warm to the touch. Nurse #1 stated she was very concerned and contacted the medical provider. She stated she received an order to send the resident to a local hospital. Nurse #1 stated the remainder of the resident's assessment was normal. She indicated she was not aware of the fall on 9/14/20 until after the resident was sent to the emergency room. A progress note dated 9/15/20 at 6:10 PM written by Nurse #2 revealed when Resident #1 returned from the hospital she notified the resident's physician of the incident. The note revealed a	F 600		

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new order for Norco to be given every 4 hours as needed.

A review of the Medication Administration record (MAR) revealed Resident #1 was being monitored for pain and was to receive Acetaminophen (pain reliever) 1000 mg 3 times a day for chronic contracture and leg pain. She did not receive the pain medication until 9/15/20. She was also to receive Norco (opioid & acetaminophen for moderate to severe pain) 5 milligrams every 4 hours as needed for knee pain. Resident #1 received Norco on 9/16/20 at 7:26 PM, on 9/17/20 at 1:50 AM and 8:36 PM on 9/18/20 at 9:09 AM and 1:26 PM, on 9/19/20 at 8:51 AM and 1:05 PM, on 9/20/20 at 9:22 AM, on 9/21/20 at 7:46 AM, 4:16 PM and at 8 :51 PM. None was received on 9/22/20, one dose on 9/23/20 at 7:31 PM. None was received on 9/24/20, 0/25/20 or 9/26/20. She received 2 doses on 9/27/20 at 2:00 AM and at 7:35 PM. None was received on 9/28/20 or 9/29/20 then 2 more doses on 9/30/20 at 7:47 AM and 5:13 PM. She continued to receive Norco in October when she received 2 doses on most days except 3 doses on 10/4/20, 10/8/20, 10/14/20 & 10/15/20. She did not receive Norco on 10/6/20, 10/16/20, 10/17/20, 10/18/20 and only received 1 dose on 10/7/20, 10/19/20, 10/20/20, 10/21/20 10/24/20 and 10/25/20. None was received again until 11/1/20, 11/17/20 11/24/20 and 11/29/20. She received 5 doses in December 2020 and the order was discontinued on 1/7/21.

A record review revealed a physician note written on 10/6/20 which reported Resident #1 had a fracture of her right knee and analgesic was adequate.

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An interview with the DON on 3/24/21 at 5:00 PM revealed NA #1 did not identify the fall as a fall and did not notify the nurse on duty. The DON reported their investigation revealed Resident #1 was lowered to the floor by NA #1, but the nurse was not notified so a nursing assessment was not completed prior to Resident #1 being placed in her wheelchair. The DON added a mechanical lift should have been used to transfer the resident.

During an interview with Resident #1's physician on 3/24/21 at 3:15 PM he stated the nurse should have been notified to assess Resident #1. He said Resident #1 could have had increased pain. The physician then said a nurse should always assess a resident after a fall and the nursing assistant was not qualified to do that.

During an interview on 3/26/21 at 3:25 PM the Director of Nursing (DON) stated incontinence care for Resident #1 required two people to assist with positioning. The DON indicated NA #1 did not receive any NA orientation training or a skills check-off prior to working with residents as a nurse aide. She stated it was during the COVID-19 outbreak and they needed NA #1 due to staffing shortage. The DON stated she did not realize NA #1 did not receive NA training until after the incident with Resident #1.

The facility provided a corrective action plan with a correction date of 9/21/20. The facility's plan of correction included the following information:

F 600
Corrective action for the affected resident

On 09/14/2020 at 9:22PM MD was notified by the hall nurse of the affected resident with swelling to

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her right leg. The R/P was notified by nurse at 6:21AM. Resident was sent to ER for evaluation of right leg edema.

Corrective action for residents with potential to be affected

Beginning on 09/17/2020, the hall nurses under the direction of the Director of Nursing assessed all current residents. This was accomplished by the hall nurse completing a full body skin assessment for the following indicators: Signs and symptoms bruises, skin tears, abuse, neglect, mood or behavior changes, signs or symptoms of a fall or injury or signs of substandard care. The audits were completed by 09/18/2020. The Director of Nursing reviewed each audit on 09/18/2020 for any findings or concerns and none were identified.

Systemic changes (education)

Beginning on 09/18/2020, the Regional RN Staff Development Coordinator, Director of Nursing, and Nursing Home Administrator completed Corporate compliance, CNA competency skills check list, Lift training with checklist, and Kardex training with checklist on all full time, part time, and PRN CNA's. This training was completed by 09/21/2020 with the exception of two employees on FMLA. The two employees on FMLA received the education and skills check list on their return back to work on 09/21/2020 and 09/30/2020. There have been no new hire CNA's or department transfers since 09/18/2020.

Beginning on 09/18/2020 the Director of nursing completed the Agency orientation packet and Lift training skills check list on all current CNA agency

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contracts. This was completed on 09/18/2020 and continued as new agency CNA contracts were required.

On 09/15/2020 All clinical Staff RN's, LPN's, and CNA's full time, part time and PRN were educated on the following:

Definition of fall
· Processes of responding to a fall
· Notifying nurse with any incident/fall
· Initiating falls protocol
· Assessment & Documentation of falls

This education was provided by the Director of Nursing and Nursing Home Administrator and was completed by

I. Definition of fall:

Definition of a fall: a "fall" refers to unintentionally coming to rest on the ground floor, or other lower level, but not as a result of an overwhelming external force. A fall without an injury is still to be considered a "fall". If a resident is found on the floor, it is to be considered a "fall". If you assist a resident to the floor, it is considered a "fall". If a resident trips and catches themselves or a staff member catches them, it is considered a "fall".

II. Reporting of Incidents & fall:

All incidents and falls are to be reported to the nurse and DON immediately. A nurse is to assess the resident prior to being moved. Please do not wait until end of shift or later to report to the nurse. When any staff member finds a resident that has had an incident or a fall; contact the nurses ASAP.

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F 600	Continued From page 11 III. Assessments, Documentation, Notifications of Incidents & Falls: The following education was provided to all nurses. 1. Nursing is to complete a head to toe assessment after an incident/fall and as needed, including vital signs. With every fall, a Falls UDA (Neuro assessment) is to be completed at the time of occurrence, then q hour x 4, then q shift x 48 hours. 2. Nursing is to assess cervical alignment, head injury, extremity alignments, any external or internal rotation of extremities prior to resident being moved. 3. Nursing is to notify the Provider and RP immediately with each incident/fall. Quality Assurance Plan The Director of Nursing or Nursing Home Administrator or designee will complete the clinical QA audit once per week times two then monthly times two. Reports of the monitor will be given by the Nursing Home Administrator to review in monthly QA. Any concerns will be addressed and immediate corrective action will be initiated as appropriate. The Quality of Life Committee meets consist of the Director of Nursing, Nursing Home Administrator, Dietary Manager, Social Worker, Health Information Manager, and meets monthly. Allegation of compliance date: 09/21/2020 The corrective action plan was verified through review of the education provided to the nurses and nursing assistants, skills checklist for nursing assistants, a review of the audit tools and	F 600		

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F 600	Continued From page 12 monitoring documentation and the quality assurance meeting minutes. An observation of the use of a total mechanical lift with Resident #1 was completed on 3/24/21 at 1:40 PM. NA #2 and NA #4 utilized the mechanical lift to move Resident #1 from her wheelchair to her bed. Reassurance was provided to the resident during the process. Review of staff training records revealed NA #1 received initial orientation nurse aide training and a skills check-off for mechanical lift training dated 9/18/20. The facility was verified to be in compliance on 9/21/20.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her	F 609		4/9/21

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 03/29/2021

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 609	Continued From page 13 designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report a neglect allegation to the State Agency within the required time frame for 1 of 3 residents reviewed for accidents. (Resident #1). The findings included: Resident #1 was admitted to the facility on 2/27/19 with diagnoses that included dementia, contractures of both knees and hypothyroidism. Review of Resident #1's quarterly Minimum Data Set assessment, dated 7/6/2020 revealed she was assessed as severely cognitively impaired. The assessment revealed that Resident #1 required extensive assistance of two or more people for bed mobility and transfers. She was assessed as dependent with the assistance of two people for dressing, toilet use and bathing. A review of a progress note dated 9/15/21 at 6:34 AM revealed Nurse #1 entered the room to assess the resident. Resident was found to have a swollen area covering enire right upper leg. Area was warmer than other extremity and painful. The facility's medical director was notified of the concern and an order was received to the hospital for further evaluation. Review of a progress note dated 9/15/20 at 8:25 AM revealed that on 9/14/20 Resident #1 was	F 609	F609 SS=D 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 citedhave been or will be corrected by the dates indicated. Mation Corrective Action for Residents Affected Resident #1 Confirmation of Fracture was received 9/15/20 at 3:30 PM. 24 Hour Initial Report was transmitted via facsimile 9/16/20 at 4:00 PM Corrective Action for Resident Potentially Affected. 100% of prior year 24-Hour Initial Reports were audited and all were submitted timely. No reports have been completed since 9/16/20. Systemic Changes The Business Office Manager or designee will retain facsimile confirmation reports of all attempts successful/unsuccessful made to transmit	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 609	Continued From page 14 "aided to the floor so she wouldn't fall" by Nurse Aide #1 (NA #1). NA #1 and NA #2 assisted Resident #1 from the floor into her wheelchair. The note revealed Resident #1 did not complain of any injury. A review of the resident's medical record included a Radiology Report dated 9/15/20 at 10:12 AM. Significant finding from the Radiology Report revealed the resident had an acute oblique fracture of the distal metaphysis of the right femur (area above the knee joint). Oblique fractures are slanted fractures that occur when force is applied to any angle other than a right angle to the bone. The facility's Administrator completed an Initial Allegation Report to the State Agency on 9/16/20. The report designated this type of allegation as "Resident Neglect" and reported the facility became aware the incident occurred on 9/14/20 at 6:00 PM. Allegation details noted resident had a fractured right distal femur (bone above the knee joint). The Transmission Certification Report was dated and timed as 9/16/20 at 4:07 PM. An interview with the Business Manager on 3/23/21 at 2:25 PM was conducted and she stated she faxed the report. She further stated the date and time of the Transmission Certification Report was accurate. An interview was conducted with the Administrator on 3/23/21 at 3:00 PM who stated staff were focused on insuring safety of the resident and the date and time the report was sent was accurate.	F 609	24-Hour Initial Reports to verify efforts made to summit timely. Quality Assurance The Administrator or Business Office Manager will audit all future 24 Hour Initial Reports to ensure all facsimile confirmation documents are attached including successful and unsuccessful attempts. These audits will be done with any reportable incidents. 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.	