STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING _____ B. WING _____	C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKSIDE CARE & REHABILITATION CENTER	**604 STOKES STREET EAST AHOSKIE, NC 27910**

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; 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 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. 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 or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal	F 156		11/6/14

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

Electronically Signed | 10/24/2014

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 156	Continued From page 1 funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to include the reason for Medicare decertification in the notice of Medicare non-coverage for 3 of 3 residents (#170, #118 and #23) reviewed for liability notices, and failed to ensure the resident or representative was notified of decertification at least 48 hours in advance for 1 of 3 residents (#118). The findings included: 1. Review of a "Notice of Medicare Non-Coverage" form for Resident #118 revealed coverage for current Medicare services would end 9/5/14. The form was signed by the representative on 9/5/14. No reason for termination of coverage was included in the notice. During an interview on 10/9/14 at 9:02 AM, administrative staff #2 said she called family to discuss planned discharges when a date of decertification was determined but she did not document such calls. During an interview on 10/8/14 at 4:57 PM, the administrative staff (administrative staff #1) responsible for issuing the decertification notices stated she did not typically include a reason in the notice. Administrative staff #1 indicated the resident and/or representative was told verbally of the reason. She added that if the facility was unable to reach the representative by phone she would include the reason in the notice. 2. Review of a "Notice of Medicare Non-Coverage" form for Resident #23 revealed coverage for current Medicare services would end 5/7/14. No reason for termination of	F 156	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed either, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. F 156 1. Resident #118, #170, and #23 are no longer residing in the facility. 2. All current and future Medicare/Medicaid residents have the potential to be affected. MDS (Casemix) Nurse and the Social Services Department have been educated by Administrator on completion of notice of Medicare non-coverage and reason for	

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F 156	Continued From page 3 coverage was included in the notice. During an interview on 10/8/14 at 4:57 PM, the administrative staff (administrative staff #1) responsible for issuing the decertification notices stated she did not typically include a reason in the notice. Administrative staff #1 indicated the resident and/or representative was told verbally of the reason. She added that if the facility was unable to reach the representative by phone she would include the reason in the notice. 3. Review of a "Notice of Medicare Non-Coverage" form for Resident #170 revealed coverage for current Medicare services would end 9/29/14. No reason for termination of coverage was included in the notice. During an interview on 10/8/14 at 4:57 PM, the administrative staff (administrative staff #1) responsible for issuing the decertification notices stated she did not typically include a reason in the notice. Administrative staff #1 indicated the resident and/or representative was told verbally of the reason. She added that if the facility was unable to reach the representative by phone she would include the reason in the notice.	F 156	decertification. Education included that resident or representative must be notified of decertification at least 48hrs in advance. Training was held 10/21/14. 3. All current and future residents will receive Non Coverage letters and notification 48 hrs. before discharge which will include reason for termination effective 10/30/14. 4. Administrator and/or Business Office Manager will audit all Non Coverage Letters and documentation weekly x 4 weeks and Monthly x 3 on a Quality Improvement Tool. Findings and results will be reported to the Performance Improvement Committee by Administrator x 3 Months. Any issues or trends identified will be addressed weekly by the Administrator and plans will be adjusted to ensure continued compliance by re-education of staff and/or counseling. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Quality of Life Coordinator, Dietary Manager, Maintenance Director, Medical Director, Director of Social Services, and Environmental Services.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative	F 157		11/6/14

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F 157	Continued From page 4 or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to notify the Doctor of an abnormal lab value for one of one residents, Resident # 57. The findings included: Resident #57 was admitted to the facility on 9/3/2014. Diagnoses included but were not limited to Alzheimer's dementia with behavior disturbance, diabetes, hypertension, dysphagia,	F 157	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings.	

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F 157	Continued From page 5 seizure disorder, and history of stroke. The most recent comprehensive assessment, dated 9/26/2014, documented Resident #57 with severe cognitive impairment. Review of Resident #57's records revealed a lab report dated 9/30/14, which documented a hemoglobin (Hbg) level of 8.0 grams, with normal Hgb in the range of 11.1 to 15.9 grams. The hematocrit (Hct) level was 24.4%, with normal levels in the range of 34.0 to 46.6%. The report had a date stamp of "faxed 9/30/14." There was no documentation found in the medical record to identify that the Medical Doctor (MD) was notified. No physician progress note or physician orders were found to address the low hemoglobin and hematocrit level. On 10/9/14 at 10:10AM an interview was conducted with the Director of Nursing (DON). The DON stated that the lab values should be faxed to the MD, and a phone call should be made if the values were abnormal, and then the nurse should document the notification in the resident's medical record. The DON could find no documentation to support a phone call was made to the MD, and no documentation from the MD that he was aware of the abnormal lab values. An interview was conducted on 10/9/14 at 4:24PM with the MD. The MD stated that the facility had called him earlier in the day and informed him of the abnormal Hgb, and he was aware of it and had left orders to address it. When they surveyor informed him that the Hgb was drawn on 9/29/14 and reported to the facility on 9/30/14, the MD stated he thought this result had just come in today. He stated that he was going to need another Hgb from today then to compare since that value was 10 days old. The MD stated that his expectations for abnormal lab	F 157	This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. F 157 1. Director of Nursing assessed resident 10/9/14 upon awareness of H & H values. Resident #57 Physician was notified immediately on 10/9/14 and informed that resident was stable and asymptomatic. However the evening of 10/9/14 the Physician, felt it would be beneficial to send resident out to hospital related to Hemoglobin of 8 grams on 9/30/14 to determine need of possible blood transfusion. Resident was sent to VRC Hospital on 10/9/14 @ 1715, lab results drawn at the hospital Emergency Room showed a hemoglobin value of 9.5 normal ranges are (11.1-15.9) great improvement noted with no need for transfusion at that time. Resident returned to facility on 10/9/14 at 2130.	

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F 157	Continued From page 6 values was for the facility to call him right away.	F 157	2. All residents have the potential to be affected. 100% Audit will be completed by 11/3/14 of all medical records. As abnormalities are found they will be address by informing Physician and families. The Director of Nursing has educated all Licensed Nursing staff on the Lab Processes and Physician & Family Notifications as of 10/29/14. 3. Physician and Residents legal representative will be notified of all abnormal labs and changes in conditions. Licensed Nurses will complete a Situation Background Assessment Recommendation form (SBAR) which is used as a best practice for standardized communication to share resident information in clear, concise and standard format; improving communication efficiency and accuracy this also includes date and time of Physician and family notification. Licensed nurses will be responsible for notification and documentation of Physician and responsible parties response to change of condition. Physicians response will be documented on the Situation Background Assessment Recommendation form and on physician's telephone order. All labs, new orders, and SBARs will be reviewed Monday- Friday by the Director of Nursing's Clinical White Board Meeting for compliance. (The Clinical White Board meeting is intended to track residents with issues such as falls, skin integrity, on antibiotics, labs, behaviors, along with other issues identified by the Director of nursing, Administrator and/or the	

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F 157	Continued From page 7	F 157	Performance Improvement committee or staff.)The Director of Nursing or Assistant Director of Nursing will review Situation Background Assessment Recommendation tool and physician telephone orders Monday-Friday in Clinical Whiteboard to ensure that Physician has been notified and responded and that orders are being carried out. This will be monitored on a Quality Assurance tool. Also in attendance for the White Board Meeting are two Assistant Director of Nurses, the Unit Manager, the Staff Development Coordinator, the Wound Nurse, and the Administrator. 4. Director of Nursing, Assistant Director, and/or Unit manager will audit each Situation Background Assessment Recommendation Form and Labs for Physician and family notification five days per week for four weeks, then weekly for 3 months. Physician responses will be documented by licensed nurses on the Situation Background Assessment Recommendation form and Physician Telephone Orders. Situation Background Assessment Recommendation forms and telephone orders will be monitored by Director of Nursing and/or Assistant Director of Nursing to ensure physician has been notified, has responded and orders are being carried out. Any issue or trend identified will be immediately addressed, corrected, and the identified staff will receive immediate re-education and plans will be adjusted to ensure continued compliance. Findings and	

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F 157	Continued From page 8	F 157	results will be documented on a Quality Assurance Tool and reported to the Performance Improvement Committee by the Director of Nursing, Monthly x3 for their review and recommendations. The results of this audit will be brought to the Quality Assurance/Performance Improvement Committee Meeting by the Director of Nurses. The Performance Improvement Committee consists of the Administrator, Director of Nursing, Staff Development Coordinator, ADON, Quality of Life Coordinator, Dietary Manager, Maintenance Director, Medical Director, Director of Social Services, and Environmental Services.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to obtain stool hemoccult per Doctors order for one of one resident, Resident #57. The findings included: Resident #57 was admitted to the facility on 9/3/2014. Diagnoses included but were not limited to Alzheimer's dementia with behavior disturbance, diabetes, hypertension, dysphagia,	F 309	Creekside Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings.	11/6/14

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F 309	Continued From page 9 seizure disorder, and history of stroke. The most recent comprehensive assessment, dated 9/26/2014, documented Resident #57 with severe cognitive impairment. A review of Resident #57's medical records revealed a physician order dated 9/12/14 for stool hemoccult x 3. A stool hemoccult test checks for the presence of hidden blood in the resident's stool. This test was ordered because a lab report dated 9/12/14 documented that Resident #57 had a low Hemoglobin (Hgb) of 8.9 grams, with normal Hgb in the range of 11.1 to 15.9 grams. A nurse's note dated 9/16/17 stated "had large BM (bowel movement) this afternoon." There was no documentation that the stool hemoccult test was collected. There was no documentation in the laboratory reports that a stool hemoccult test had performed for this resident. A laboratory report dated 9/29/14 documented a Hgb of 8.0 grams. On 10/9/14 at 6:20 PM an interview was conducted with the Director of Nursing (DON). The DON stated that when orders were taken off the chart for the hemoccults that needed to be done, they would be placed on the resident's electronic medication administration record (MAR). Resident #57's MAR revealed that the hemoccult test orders were present. The DON could not find any documentation that the hemoccult tests had been collected by the nurse and sent to the lab. The DON could not find any documentation that hemoccult test results were available for Resident #57. An interview was conducted on 10/9/14 at 4:24 PM with the resident's Medial Doctor (MD). The MD stated that the facility had called him earlier in the day and informed him of the abnormal Hgb, and he was aware of it and had left orders to address it. The Hgb was drawn on 9/29/14 and	F 309	This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. F 309 1. Resident # 57□s physician was consulted on 10/09/14 and informed that hemoculs had not been obtained. New order obtained on 10/09/14 to send to ER for Evaluation and testing. Resident returned same day in stable condition and hemoglobin & hematocrit stabilized at 9.5 grams. 2. All residents have the potential to be affected. 100% Audit of all resident medical records will be completed by 11/3/14 to ensure labs are obtained as ordered. Audits will be completed by Director or Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, and Wound Nurse. The Director of Nursing has educated all Licensed Nursing on Processing Labs, Entering Hemoculs in Medication	

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F 309	Continued From page 10 reported to the facility on 9/30/14, the MD stated he thought this result had just come in today. A nurse's note written at 4:30PM on 10/9/14 documented "received orders from MD to send to ER (emergency room) for eval (evaluation) and treat (treatment)."	F 309	Administration Record, Recording Hemocults needed on 24hr Report and documenting positive results on Situation Background Assessment Recommendation form when reporting it to the Physician & Family as of 11/3/14. 3. All physician orders will be followed. The Licensed nurse will document on the Medication Administration Record when Hemmocult testing is required. All residents with new orders for hemocult stools will be reviewed by Director of Nursing five days per week in the Clinical White Board Meeting. The Director of Nursing will acknowledge and verify completion on the Quality Assurance Tool. Any positive results will prompt the Licensed Nurse to complete a Situation Background Assessment Recommendation form to include date and time of Physician and family notification. 4. Director of Nursing or Assistant Director of Nursing will audit each Situation Background Assessment Recommendation form and lab for Physician and family notification five days per week on the Quality Assurance tool. This will be done five days per week for four weeks then weekly for three months. Any issue or trend identified will be immediately addressed, corrected, and the identified staff will receive immediate re-education and plans will be adjusted to ensure continued compliance. The results of the audits will be brought to the Quality	

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F 309	Continued From page 11	F 309	Assurance/Performance Improvement Committee by the Director of Nursing. The Performance Improvement Committee consists of the Administrator, Director of Nursing,Assistant Director of Nursing,Staff Development Coordinator, Medical Director, Quality of Life Coordinator, Dietary Manger, Maintenance Director, Director of Social Services and Environmental Services Director.	