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 11/26/2013

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

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review, observations, interviews with staff and family, the facility failed to report and investigate injuries of unknown origin for one of one resident (Resident # 1.) The findings included: Review of the 14-Day Minimum Data Set (MDS) Assessment dated 11/14/13 indicated Resident # 1 was admitted to the facility on 10/29/13 with diagnoses that included hypertension, dementia, late effects of cerebral vascular disease, and muscle weakness. Further review of the MDS revealed the resident required extensive assistance for activities of daily living, including bed mobility, personal hygiene, transfers, and toileting, and that she was frequently incontinent of bladder and bowel. The same MDS revealed the resident was cognitively impaired with a Brief Interview for Cognitive Status score of 9. A review of the facility's Abuse, Neglect, and Misappropriation Policy, effective 04/2013 and revised on 03/2013, revealed the following statement, " All allegations of abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator of the facility along with other officials in accordance with State law through	F 226	F226 The incident for resident #1 was investigated. All resident have the potential to be affected. All current daily reports were audited to see if any bruising met the criteria to be investigated as abuse. The abuse investigation policy was reviewed and found to be appropriate, so all licensed staff was inserviced on reporting bruises of unknown origin, as stated in the policy. The DON or designee will audit the incident reports for two weeks to see if any bruises of unknown origin were not reported, and act appropriately if warranted. The results of this audit will be reported to the next Performance Improvement committee meeting, which meets monthly and is attended by the DON, administrator, the medical director, the RpH, and several department managers.	Dec 1

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: Dec 2 2013 (SIGNED 9 JAN)

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 226	Continued From page 1 established guidelines. " Additional review of the same policy revealed that staff received ongoing training regarding identification and prevention of abuse, as well as information regarding what constitutes abuse and neglect. The policy indicated that training on " Signs and Symptoms of abuse (bruises, injuries of unknown origin, crying, fearful, increased agitation, and withdrawal) " were included in the staff training, as well as when and to whom to report abuse. A review of the physician's orders revealed the resident was taking Plavix on a daily basis. A review of the Nursing Admission Skin Evaluation (NASE) dated 10/29/13 revealed the resident had reddened areas to the buttocks and bruising bilaterally on the upper extremities and hands. The evaluation was signed by the Wound Nurse and by Nurse # 1. Review of the Weekly Skin Integrity Review (WSIR) dated 10/29/13 revealed the resident had some bruising upon admission on the right lower arm about 3 inches by 3 inches in size. The same WSIR was signed by Nurse #1. Review of the WSIR dated 10/30/13 indicated the resident had bruises on the left arm wrist area and the lower right abdomen. Further review of the assessment revealed the resident had "old spots" on the front outer shins. The assessment was signed by the Wound Nurse. Review of the WSIR dated 11/07/13 indicated the resident's skin was intact. No other notations were made on the report regarding new or old bruising, and the report was signed by the Wound Nurse. Review of the WSIR dated 11/14/13 revealed the resident had bruises on the backs of her left and right hands, the back of the right arm, and the back of the right thigh. There was no further description of the bruises included in the report.	F 226		

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F 226	Continued From page 2 The assessment was signed by Nurse #2. Review of the WSIR dated 11/21/13 indicated the resident had bruises and redness in the perineal area. A box on the same WSIR report was checked to indicate the reported areas were new. The assessment was signed by Nurse #2. Review of the Nurse ' s Notes dated 11/23/13 at 1:00 AM revealed the family of the resident complained that the resident had bruises that were not there the day before. The Nurse's Note was signed by Nurse #3. A review of the facility ' s Grievances/Concerns for November 2013 revealed there was no grievance, concern, or report of bruises or an injury of unknown origin for Resident #1. During an interview with the Resident #1's Responsible Party (RP) on 11/25/13 at 10:48 AM, the RP stated that the resident had bruising located on the left outer thigh between the hip area and the knee which he had not seen on his previous visit. He stated he saw the bruising the last time he visited at the facility on 11/22/13, and further stated that there were other times when he noted new bruises on the resident while she was in the facility. He stated that he felt the bruising might suggest either intentional or unintentional abuse. In an interview conducted with Nurse #2 on 11/25/13 at 4:40 pm, she stated that her documentation of the bruises located on the back of the resident's right and left hands, as well as the bruise on the back of the right thigh were not new bruises on her assessment (WSIR) on 11/14/13. In addition, she stated that her notation of bruising and redness on the WSIR dated 11/21/13 indicated that new redness was present in the resident's perineal area. She then added that she felt the bruising noted at that time was old. She explained that she felt no need to	F 226		

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F 226	Continued From page 3	F 226		

contact the supervisor about the bruising because all the bruises were old.
During an interview with Nurse #3 on 10/25/13 at 5:40 PM, she stated the bruising she described in her Nurse's Note dated 11/23/13 at 1:00 AM was old bruising, and that she did not feel she should contact a supervisor to report it as an injury of unknown origin. She added that the RP who had visited that evening was very concerned about the bruises and was very concerned in general about the resident's care.
During an interview with the Wound Nurse on 11/25/13 at 4:45 PM, she confirmed that she indicated there was a bruise noted on the resident's lower right abdomen on the WSIR dated 10/30/13. She also stated she did not know how a resident would typically receive a bruise in the lower right abdomen. In addition, she stated the "old spots" noted on her WSIR dated 10/30/13 referred to "age spots." She stated that she did not report the abdominal bruising to her supervisor. She then added that if she suspected verbal, physical, or sexual abuse of any kind on a resident, she would immediately contact her supervisor so that action could be taken to remove the resident from harm and so that an investigation could be made. She also stated that she had received abuse training in the facility about one month ago.
An observation of incontinent care by Nursing Assistants #1 and #2 on 11/26/13 at 10:15 AM revealed the resident had two quarter size light blue bruises; one on the upper, outer thigh near the hip, and one on the mid-level outer thigh area. There was no redness and no bruising noted on the upper or lower inner thighs bilaterally, and no bruising was observed on the resident's back right thigh. Immediately after the incontinent care was complete, an observation of the resident ' s

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F 226	Continued From page 4 upper arms was made. There was a small light blue/yellow bruise noted on the upper back arm shaped like a pencil line. The bruise was approximately 2 inches long and was dotted in appearance. During a second interview with the Wound Nurse on 11/26/13 at 10:00 AM, she confirmed there was no bruising noted on her WSIR dated 11/07/13. She also stated that the bruising noted by Nurse #2 on the WSIR the following week dated 11/14/13, including the bruise on the back of the right thigh, must have been new because it had not been present on the WSIR dated 11/07/13. During an interview with the Abuse Coordinator at 11:06 AM on 11/26/13, she stated that the entire staff of the facility had received Abuse Training during the month of August 2013 and added that another in-service training is scheduled to take place on December 15, 2013. She explained that all aspects of the Abuse Policy were included in the training, including reporting injuries of unknown origin. She also stated that when employees are hired, they receive Abuse Training during the first three days of orientation. During an interview with Staff Development Coordinator (SDC) on 11/26/13 at 4:50 PM, she provided sign-in sheets for abuse policy training on the following dates: 08/04/13, 08/05/13, 08/06/13, 08/14/13, 08/15/13, 08/16/13, and 08/23/13. During an interview with the Director of Nursing (DON) on 11/26/13 at 5:50 PM, she stated that it is her expectation that a nurse would contact her about any multiple bruises or injuries of unknown origin so that a proper investigation could be made. The DON also stated she was not aware of any injuries of unknown origin for Resident #1. After the DON reviewed the Nurse's Notes dated	F 226		

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F 226	Continued From page 5 11/23/13 at 1:00 AM which were signed by Nurse #3, she stated that Nurse #3 had called her that evening, but did not mention bruising or an injury of unknown origin for the resident. She added that she would have come to the facility on that night if she had realized there was new bruising on the resident, especially if the resident's RP was concerned. She also stated that she had not been notified of any injuries of unknown origin at any time since Resident # 1's admission.	F 226		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide incontinent care for 1 of 2 (Resident #1) sampled residents that required assistance with Activities of Daily Living (ADL ' s). The findings included: 1. Resident #1 was admitted to the facility on 10/29/13 with diagnoses that included late effects of cerebral vascular disease, muscle weakness, and dementia. The 14-day Minimum Data Set (MDS) dated 11/14/2013 documented the resident required extensive assistance with toileting and that she was frequently incontinent of bladder and bowel.	F 312	F312 The care for the specific resident was provided. Training on providing ADLs was provided to the licensed staff and CNAs . The DON or designee (nurse) will audit 10/week for four weeks of actual provision of ADL incontinent care to residents by CNAs. Remedial training will be provided immediately at point of care for errors observed.	DEC 1

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F 312	Continued From page 6 During an observation on 11/25/2013 at 1:57 pm, incontinent care was provided by NA #1. The NA removed the resident ' s moderately saturated brief. The NA wiped the perineal area with a disposable wipe from the front (perineum) to the back (rectal) area. An observation of the wipe revealed the resident had been incontinent of stool. The NA proceeded to wipe the front of the perineal area (perineum) again with the stained disposable wipe towards the back (rectal) area. The NA proceeded to pat dry the perineum in the same front to back, back to front motion. The NA then applied a dry incontinent brief. On 11/25/2013 at 2:10 pm, during an interview, NA #1 stated she was aware that she should change the wipe or clean with a different area of the wipe. She further stated " I just got to be more cautious the next time. " During an interview on 11/25/2013 at 6:40 pm, the Director of Nursing (DON) stated she expected the NA ' s to use the disposable wipes only for the breakdown of the fecal matter. The DON further stated she expected the NA ' s to ensure proper infection control is maintained by wiping from front to back with a single use of the disposable wipe.	F 312	The results of this audit will be reported to the next Performance Improvement committee meeting, which meets monthly and is attended by the DON, administrator, the medical director, the RpH, and several department managers.	
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and	F 356		

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F 356	Continued From page 7 unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and interview with staff the facility failed to post the nurse staffing data on 1 of 3 days of the survey. The findings included: Observation during the initial tour on 11/24/13 at 9:20 PM revealed there was no posted nurse staffing data for 11/24/13. Observation was made of the daily nurse staffing sheet dated on11/24/13 that was blank.	F 356	F356 No residents were identified in this citation. No residents were found to have the potential to be affected by this practice. The policy was changed as to the specific person (position) responsible for posting this information. The DON or designee (nurse) will audit this practice for one week (7 days) to ensure the information is posted. The results of this audit will be reported to the next Performance Improvement committee meeting, which meets monthly and is attended by the DON, administrator, the medical director, the RpH, and several department managers.	DEC 1

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F 356	Continued From page 8 Observation on 11/24/13 at 11:00 PM revealed there was no posted nurse staffing data for 11/24/13. Observation was made of the daily nurse staffing sheet dated on11/24/13 that was blank. Interview with the Director of Nursing (DON) on 11/26/13 at 9:37 AM revealed that the Registered Nurse (RN) Supervisor is responsible for completing and posting the daily nurse staffing sheet by 9:00 AM each day. The DON further stated that a Nurse called out on Sunday and the RN Supervisor had to work the cart and forgot to complete and post the daily nurse staffing. DON further stated that it is her expectation that the daily nurse staffing sheet is completed and posted by 9:00 AM each morning.	F 356		