DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345204	A. BUILDING _____ B. WING _____	C 04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONECREEK HEALTH AND REHABILITATION	455 VICTORIA ROAD ASHEVILLE, NC 28801

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	***This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.*** -24 hour and 5 day working report have been submitted to the state agency for Resident 1. -Audit of incident reports for the last 30 days was completed to check for injury of unknown source. No other Residents were found to be affected. All employees in-serviced on abuse, including injuries of unknown origin, and abuse reporting procedures. -DON or designee will review all incident reports and investigate any injuries of unknown origin on an ongoing basis. -Findings from this ongoing systematic change will be reported at the next Quarterly QA meeting and continued for 3 months.	- 5/5/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: ✓ Jessica Hauser — TITLE: ✓ Administrator — (X6) DATE: ✓ 5/9/11

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.

Original Signature Date: 5-2-11

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F 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews, and medical and facility record review, the facility failed to report an injury of unknown source to the state agency within twenty-four hours for one (1) of one (1) resident with a broken leg (Resident # 1). The findings are: Resident # 1 was admitted to the facility on 05/27/10 with diagnoses of dementia, degenerative joint disease, osteoporosis, and peripheral neuropathy. The latest Minimum Data Set dated 02/17/11 revealed the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. Resident # 1 required extensive to total assistance with activities of daily living. Review of her medical record revealed that she had had a fracture of unknown source of her right leg at another facility prior to this admission with a subsequent amputation of the right leg. On 07/06/10 her physician, who had been her physician at the previous facility, wrote in his progress notes, " She is at increased risk for spontaneous fractures. " According to nursing notes and staff statements recorded as part of a facility investigation, on 04/09/11 Nursing Assistant (NA) # 1 got the resident up for the day into her wheelchair at approximately 7:20 a.m. She documented that she did not notice anything wrong with the resident's left leg and the resident had no complaint of pain during the day. Licensed Nurse # 1 documented that the resident's wheelchair footrests were in use, pillows were placed	F 225		

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F 225	Continued From page 2 beneath the resident's legs three times during the day shift, and the resident did not complain of pain nor exhibit any signs of distress. NA # 1 transferred the resident back to bed at approximately 1:30 p.m., stating again the resident exhibited no signs of pain and she did not notice anything wrong with the resident's left leg. According to nursing notes and staff statements recorded as part of a facility investigation, NA # 2 went to the resident's room at approximately 4:30 p.m. to perform incontinence care and get the resident up for dinner. She stated that as she pulled the covers back, the resident was moving as if to assist her. She noticed the resident's left leg was underneath the amputated stump of her right leg. The resident began to scream with movement and she noticed her ankle was turned to the side of her leg. NA # 2 called the nurse. The resident was assessed, the physician and family were notified, and the resident was transported to the hospital. Hospital records revealed her left leg was fractured. On 04/12/11 at 12:30 p.m. the resident's physician was interviewed by telephone. He stated the resident had a history of spontaneous fracture of her right leg at another facility while under his care, and he considered this a spontaneous fracture related to her severe osteoporosis. He stated it was impossible to know when the fracture had occurred as the resident's peripheral neuropathy could mask the pain. On 04/12/11 at 12:42 p.m. the facility Administrator was interviewed. She stated she was notified of the resident's broken leg on 04/09/11 after the resident was sent to the	F 225		

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F 225	Continued From page 3 hospital. She stated the Unit Manager told her she did not know how it had happened. She told the Unit Manager to document what she knew in the medical record. The Administrator stated that on 04/10/11 at approximately 1:30 p.m. she began her investigation by reading the resident's medical record and attempting to contact the staff who had cared for the resident on 04/09/11. She stated she continued her investigation on Monday, 04/11/11 and spoke with the family of the resident that day. The Administrator stated the family alleged someone may have broken the resident's leg on purpose. She stated that she assured the family that she was investigating the incident. The Administrator also stated her investigation was ongoing as she was still attempting to contact some staff members for interview on 04/13/11. The Administrator stated that this was an injury of unknown source, but she did not file a report with the state agency within twenty-four hours because she considered this an unwitnessed accident, based on her reading of the resident's medical record, the resident's diagnosis of osteoporosis, and her history of previous fracture. The Administrator stated she would file a twenty-four hour and five day report with the state agency for an injury of unknown source only if there were signs or allegations of abuse, and that there was neither in this case.	F 225		
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.	F 226	-24 hour and 5 day working report have been submitted to the state agency for Resident 1. --Audit of incident reports for the last 30 days was completed to check for injury of unknown origin.	

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F 226	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on staff interviews, medical and facility record review, and facility policy review, the facility failed to report an injury of unknown origin to the state agency within twenty-four hours for one (1) of one (1) resident with a broken leg (Resident # 1). The findings are: A policy provided by the facility dated 01/01/11 and entitled "Abuse" read in part: "The Director of Nursing will inform the state survey, certification, licensing agencies and other proper authorities of: 2. All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property within 24 hours. 4. The results of all investigations within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action that was taken." Resident # 1 was admitted to the facility on 05/27/10 with diagnoses of dementia, degenerative joint disease, osteoporosis, and peripheral neuropathy. The latest Minimum Data Set dated 02/17/11 revealed the resident had short and long term memory problems and was moderately impaired in cognitive skills for daily decision making. Resident # 1 required extensive to total assistance with activities of daily living. Review of her medical record revealed that she had had a fracture of unknown source of her right leg at another facility prior to this admission with a	F 226	No other Residents were found to be affected. All employees in-serviced on abuse, including injuries of unknown origin, and abuse reporting procedures. - DON or designee will review all incident reports and investigate any injuries of unknown origin on an ongoing basis. -Findings from this ongoing systematic change will be reported at the next Quarterly QA meeting for the next 3 months.	5/5/2011

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F 226	Continued From page 5 subsequent amputation of the right leg. On 07/06/10 her physician, who had been her physician at the previous facility, wrote in his progress notes, "She is at increased risk for spontaneous fractures." According to nursing notes and staff statements recorded as part of a facility investigation, on 04/09/11 Nursing Assistant (NA) # 1 got the resident up for the day into her wheelchair at approximately 7:20 a.m. She documented that she did not notice anything wrong with the resident's left leg and the resident had no complaint of pain during the day. Licensed Nurse # 1 documented that the resident's wheelchair footrests were in use, pillows were placed beneath the resident's legs three times during the day shift, and the resident did not complain of pain nor exhibit any signs of distress. NA # 1 transferred the resident back to bed at approximately 1:30 p.m., stating again the resident exhibited no signs of pain and she did not notice anything wrong with the resident's left leg. According to nursing notes and staff statements recorded as part of a facility investigation, NA # 2 went to the resident's room at approximately 4:30 p.m. to perform incontinence care and get the resident up for dinner. She stated that as she pulled the covers back, the resident was moving as if to assist her. She noticed the resident's left leg was underneath the amputated stump of her right leg. The resident began to scream with movement and she noticed her ankle was turned to the side of her leg. NA # 2 called the nurse. The resident was assessed, the physician and family were notified, and the resident was transported to the hospital. Hospital records	F 226		

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F 226	Continued From page 6 revealed her left leg was fractured. On 04/12/11 at 12:30 p.m. the resident's physician was interviewed by telephone. He stated the resident had a history of spontaneous fracture of her right leg at another facility while under his care, and he considered this a spontaneous fracture related to her severe osteoporosis. He stated it was impossible to know when the fracture had occurred as the resident's peripheral neuropathy could mask the pain. On 04/12/11 at 12:42 p.m. the facility Administrator was interviewed. She stated she was notified of the resident's broken leg on 04/09/11 after the resident was sent to the hospital. She stated the Unit Manager told her she did not know how it had happened. She told the Unit Manager to document what she knew in the medical record. The Administrator stated that on 04/10/11 at approximately 1:30 p.m. she began her investigation by reading the resident's medical record and attempting to contact the staff who had cared for the resident on 04/09/11. She stated she continued her investigation on Monday, 04/11/11 and spoke with the family of the resident that day. The Administrator stated the family alleged someone may have broken the resident's leg on purpose. She stated that she assured the family that she was investigating the incident. The Administrator also stated her investigation was ongoing as she was still attempting to contact some staff members for interview on 04/13/11. The Administrator reviewed the facility policy quoted above. She stated that this was an injury of unknown source, but she did not file a report with the state agency within twenty-four hours	F 226		

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F 226	Continued From page 7 because she considered this an unwitnessed accident, based on her reading of the resident's medical record, the resident's diagnosis of osteoporosis, and her history of previous fracture. The Administrator stated she would file a twenty-four hour and five day report with the state agency for a serious injury of unknown source only if there were signs or allegations of abuse, and that there was neither in this case.	F 226		
F 354 SS=C	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on staff interviews and facility documentation review the facility failed to ensure a Registered Nurse served as Director of Nursing for at least 35 hours a week. The findings are: An on site visit was conducted on 4/13/11 that began at 8:45 a.m. Interview with the Business Office Manager at this time revealed the	F 354	-No residents have been found to have been affected by the deficient practice. -Facility hired a Registered Nurse to serve as Director of Nursing for at least 35 hours a week. -Facility will have a Registered Nurse to serve as Director of Nursing for at least 35 hours a week. Director of Nursing began work on 4/26/2011. -Administrator will monitor Director of Nursing or designee attendance to ensure minimum coverage is met each week for 3 months. Findings will be reported at the next Quality Assurance Meeting for 3 months.	4/26/2011

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F 354	Continued From page 8 Administrator was not in the building. When asked about the Director of Nursing (DON), the Business Office Manager stated the facility currently did not have a DON. At 9:15 a.m. the Assistant Director of Nursing (ADON) met with the survey team and reported she was working a medication cart and had to find a replacement. She stated she was new to the position of ADON and confirmed the facility had been without a DON for several weeks. The ADON was unaware of a designated interim DON. On 4/13/11 at 9:40 a.m. the Administrator was interviewed and reported the facility had been without a DON since 3/23/11. She stated the Corporation's policy was that one of the Corporate Nurse Consultants or the ADON was to assume the interim role of DON until a replacement was hired. She reported that the Corporate Nurse Consultant, a Registered Nurse, was the interim DON. She stated she was unaware of the actual number of hours the Corporate Nurse spent acting as the DON in the facility. A later interview with the Administrator held at 2:45 p.m. revealed she had no verification that she had a DON assigned to cover the facility for the minimum 35 hours a week. The Administrator was unaware the designated DON was required to work a minimum of 35 hours a week in the facility. The staff schedules for 3/11 and 4/11 were reviewed and revealed no designated DON was specified on the nursing schedules. The Corporate Nurse Consultant was interviewed on 4/13/11 at 2:50 p.m. and confirmed she had been the interim DON for the facility since 3/23/11. She specified she was a full-time	F 354		

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F 354	Continued From page 9 employee of the Corporation and was working as the DON in the facility for 28 to 32 hours a week. She explained the remainder of her time was spent assisting other facilities. She offered no explanation why she was not working in the facility for the required minimum of 35 hours a week.	F 354		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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. 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. 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	F 431	-Medication was removed from Resident #3's bedside without any adverse effects. No other Residents have been found to have been affected by this deficient practice. -No Residents will have access to medications unless they have been assessed and approved for self-administration. -All licensed Nurses will be in-serviced on drug storage policy. -DON or designee will monitor one medication pass per week for two months to ensure no medications are left at Resident bedside. Findings will be reported at next Quality Assurance Meeting.	4/15/2011

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F 431	Continued From page 10 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and facility documentation review the facility failed to ensure medications were not stored at bedside for one of four sampled residents (Resident #3). The findings are: Resident #3 was admitted to the facility on 2/28/11 with diagnoses that included weakness, debility, chronic respiratory failure, hypertension among others. The most recent Minimum Data Set (MDS) dated 3/7/11 specified the resident had no cognitive impairment and required limited assistance with Activities of Daily Living (ADLs). Resident #3's care plan dated 3/15/11 specified medications were to be administered as ordered by a licensed nurse. On 4/13/11 at 10:00 a.m. the resident was observed sitting on the edge of her bed. Beside the resident was a purple disk labeled "Advair" (a medication). Resident #3 was questioned about the medication and reported it was her inhaler. At 10:05 a.m. Resident #3 left her room to attend rehabilitation services. The medication remained on the resident's bed. At 10:08 a.m. a housekeeping staff was observed to enter the resident's room and then at 10:10 a.m. the Unit Manager entered Resident #3's room and observed the medication on the resident's bed. The Unit Manager removed the medication.	F 431		

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F 431	Continued From page 11 On 4/13/11 at 10:15 a.m. the Unit Manager was interviewed and stated no residents in the facility were assessed for self-administration of medication. She confirmed the resident should not have had the medication in her room. She reviewed Resident #3's Medication Administration Record (MAR) and confirmed the resident was not to self-adminster medications. The Unit Manager reported the resident would have gotten the medication from the licensed nurse. On 4/13/11 at 10:30 a.m. licensed nurse (LN) #1 was interviewed and reported she left the medication in the resident's room when she administered the resident's morning medications at 8:00 a.m. LN #1 confirmed the medication should not have been left in the resident's room unattended. She explained that while she administering the resident's medications, she was called out of the resident's room and left the Advair medication in the room with Resident #3. On 4/13/11 at 2:00 p.m. Resident #3 was interviewed again and reported LN #1 left the medication in her room. She stated this was the first time it had happened and added she had hoped to keep the medication in her room so she could use it when she wanted.	F 431		