PRINTED: 09/30/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345204	B. WING _			C <b>09/03/2015</b>	
NAME OF PROVIDER OR SUPPLIER  STONECREEK HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, Z 455 VICTORIA ROAD ASHEVILLE, NC 28801	IP CODE	<b></b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	3	F 0	00			
F 278 SS=D	complaint investigation 483.20(g) - (j) ASSES ACCURACY/COORE	e cited as a result of the ons. Event ID ZKKJ11. SSMENT DINATION/CERTIFIED st accurately reflect the	F 2	78		9/24/15	
	resident's status.	ust conduct or coordinate h the appropriate					
	A registered nurse m assessment is compl	ust sign and certify that the eted.					
	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.						
	willfully and knowingl false statement in a r subject to a civil mon \$1,000 for each asse willfully and knowingl to certify a material a	Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money nan \$5,000 for each					
	Clinical disagreemen material and false sta	t does not constitute a atement.					
	by:	r is not met as evidenced		Disclaimer Clause:			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed 09/24/2015

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.

TITLE

NAME OF PROVIDER OR SUPPLIER  STONECREEK HEALTH AND REHABILITATION    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAGE   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAGE   PREFIX TAG   REGULATORY OR LSC IDENTIFYING INFORMATION)   TAGE   PREFIX TAGE   REQULATORY OR LSC IDENTIFYING INFORMATION)   TAGE   PROVIDERS PLANCE CORRECTION   CAMPACETION   PREFIX TAGE   PROVIDERS PLANCE CORRECTION   CAMPACETION   PREFIX TAGE   PROVIDED   PREFIX TAGE   PROVIDERS PLANCE CORRECTION   CAMPACETION   PREFIX TAGE   PROVIDED   PREFIX TAGE   PROVIDED CORRECTION   CAMPACETION   PREFIX TAGE   PROVIDED CORRECTION	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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On 08/31/15 at 12:06 PM observations of Resident #39's mouth noted 1 intact tooth and 2 broken teeth in the upper jaw. Resident #39 did not have any teeth in the lower jaw.  An interview was conducted with MDS Nurse #2 on 09/01/15 at 2:47 PM. MDS Nurse #2 reported being new to coding the MDS and thought the questions about broken and missing teeth were referring to resident's dentures. MDS Nurse #2 acknowledged seeing Resident #39 had no teeth of the lower jaw, but could not remember  status, and was transmitted to state database on 9/1/15. Resident #39; s plan of care was also updated at that time to include ongoing monitoring of dentation for any potential changes or needs on 9/1/15. Identification of other residents with potential to be affected. All residents currently residing at facility had a physical inspection of their oral cavity completed on 9/18/15. The results from these physical inspections were		oure plan.				•		
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referring to resident's dentures. MDS Nurse #2 acknowledged seeing Resident #39 had no teeth of the lower jaw, but could not remember  had a physical inspection of their oral cavity completed on 9/18/15. The results from these physical inspections were		being new to coding	the MDS and thought the		potential to be affected.			
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of the lower jaw, but could not remember from these physical inspections were								
		,						
visualizing teeth of the upper jaw. cross referenced with most previous		visualizing teeth of th	e upper jaw.					
answer from comprehensive assessment.		A iti	docted with the D'					
An interview was conducted with the Director of  All residents that are currently scheduled					I	•		
Nursing (DON) on 09/03/15 at 12:19 PM. The to receive a comprehensive MDS								
DON stated her expectation was information assessment within next month (9/18/15 -		1			I	,		
recorded in the MDS assessments would be 10/18/15) will have such completed in a						•		
accurate so a proper care plan could be timely and accurate manner. Any developed. residents that require a modification of			care plan could be					
most recent comprehensive assessment		ueveloped.			•			
will have such modification completed to					-			
accurately reflect dental status and						•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345204 B. WING			1	C 02/204 <i>E</i>			
NAME OF PROVIDER OR SUPPLIER			1	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 09/	03/2015	
STONECREEK HEALTH AND REHABILITATION				45	55 VICTORIA ROAD SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			(X5) COMPLETION DATE	
F 278	SPREAD, LINENS  The facility must esta Infection Control Prog safe, sanitary and con	CONTROL, PREVENT  blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission		278	transmitted to state database by 9/23/1 Measures / systemic changes made to ensure no future reoccurrence.  All personnel currently employed in a position which requires completion of Section L on MDS is have received education regarding proper coding techniques by Corporate Director of MI / Compliance Services on 9/3/15. All personnel have been able to provide appropriate verbal responses related to questions regarding coding of Section Monitoring of corrective actions and ensuring such actions are sustained. An audit will be completed weekly for foweeks to ensure that all residents, requiring a comprehensive MDS per OBRA schedule, are appropriately code by at least 2 persons employed in a position that requires completion of MD (who did not complete Section L on MD being reviewed) these audits will be reviewed at the monthly QAPI meeting all audits are in compliance, the QAPI committee will direct ongoing audits an review of at least 10 MDS is, not to be less than monthly for 6 months. The QAPI committee will direct course of action thereafter.	DS DS DL. DUIT DS DS DS	9/24/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345204		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345204	B. WING_		C 09/03/2015		
NAME OF PROVIDER OR SUPPLIER  STONECREEK HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	·		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 441	Program under whice (1) Investigates, con in the facility; (2) Decides what proshould be applied to (3) Maintains a reconactions related to inform (b) Preventing Spread (1) When the Infection determines that a reprevent the spread of isolate the resident. (2) The facility must communicable disease from direct contact will train (3) The facility must hands after each direct contact will train (3) The facility must hand washing is indiprofessional practices (c) Linens Personnel must hand	Program ablish an Infection Control h it - trols, and prevents infections  cedures, such as isolation, an individual resident; and rd of incidents and corrective rections.  ad of Infection on Control Program sident needs isolation to of infection, the facility must  prohibit employees with a use or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their rect resident contact for which cated by accepted	F 4	41			
	by: Based on observati interviews the facility glucose meter, a masugar, according to	r 1 of 1 resident observed for		Disclaimer Clause: Preparation and or execution does not constitute admission agreement by the Provider of facts alleged or conclusion se statement of deficiencies. The	or the truth of t forth on the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345204	B. WING _			09/	03/2015
NAME OF PROVIDER OR SUPPLIER  STONECREEK HEALTH AND REHABILITATION				45	REET ADDRESS, CITY, STATE, ZIP CODE 5 VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441	glucose meter should disinfectant wipe afte be wiped on all surfact the disinfectant wipe wet for 1 minute befo On 09/02/15 at 4:19 for medication administration blood glucose meter wiped it with an alcohosupplies and began worth to perform a blo Nurse #1 was stoppe entering Resident #5 finger stick.  An interview was con PM with Nurse #1. She blood glucose meter between residents. It disinfectant wipes in a could be used to clear but she didn't use the monitor to be too wet she was not aware of for cleaning blood glucose meters be well an interview of 4:22 PM with the Direstated it was her experienced in each medical The DON stated the libe thoroughly wiped of the stated in each medical medic	glucose meter ctions indicated the blood I be disinfected with a r each use, the meter should ces until completely wet with and the meter should remain re the next use. PM during observation of ation Nurse #1 removed a from the medication cart and rol wipe, gathered her valking to Resident #57's rood glucose finger stick. d by the surveyor before 7's room to perform the ducted on 09/02/15 at 4:20 re stated she cleaned the with an alcohol wipe She stated there were the medication cart that re the blood glucose meter rem because they caused the rem because they caused the value #1 further stated what the facility policy was recose meters. reconducted on 09/02/15 at rector of Nursing (DON) she rectation for blood glucose with the disinfectant wipes cation cart after each use. remain visibly wet for 1	F	441	prepared and or executed solely becautit is required by the provisions of the Stand Federal law.  Corrective action accomplished for resident that was affected. An individual glucometer was provided Resident #57 on 9/23/15 that will be stored in a plastic sealable bag that will stored on the medication cart. The bag and the glucometer were clearly and legibly labeled with Resident #57¿s name. The individualized glucometer be disinfected after each use per manufacturer¿s instructions with all nursing personnel. Upon discharge fror facility, this glucometer will be properly disinfected and stored in a new plastic sealable bag by the infection control nurse.  Identification of other residents with potential to be affected. All residents requiring blood glucose monitoring per MD order have been identified and an individual glucometer was provided on 9/23/15 that will be stored in a plastic, sealable bag stored the medication cart. The bags and glucometers were clearly and legibly labeled with each resident¿s name. The individualized glucometers will be disinfected per manufacturer's instructions by all nursing personnel. Upon discharge from facility, this glucometer will be properly by the infection control nurse.  Measures / systemic changes made to ensure no future reoccurrence.	for I I I I I I I I I I I I I I I I I I I	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345204	B. WING _		09/0	03/2015	
NAME OF PROVIDER OR SUPPLIER  STONECREEK HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE  455 VICTORIA ROAD  ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			
F 441	Continued From page	÷ 5	F	All licensed nursing personnel currentlemployed received education regardin proper disinfection of glucometers by the Director of Nursing, the Staff Development Coordinator and the Weekend Coordinator between 9/18/1 and 9/21/15. The licensed nursing personnel were able to provide verbal response with positive answers regard disinfection techniques.  This education included: The Policy & Procedure regarding maintaining individualized glucometers for all resid requiring blood glucose monitoring as as written instructions for proper disinfection of glucometers per manufacturer is recommendations. All licensed nurses hired after 9/21/15 will receive the same information during orientation period. All residents admit after 9/23/15 will receive individualized glucometers that will be labeled with resident name and will be disinfected pranufacturer; recommendations.  Monitoring of corrective actions and ensuring such actions are sustained. An audit will be completed weekly for feweeks to ensure that all residents that require glucose monitoring have an individualized glucometer that is propestored and labeled. These audits will be conducted by the DON(or designee) and will be reviewed at monthly QAPI Meet If all audits are in compliance, the QAF Committee will direct ongoing audits a review, not to be less than monthly for months. QAPI committee will direct course of action thereafter.	g he 15 ling ents well l tted l ber four		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
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STONEON	LEK HEALIH AND KEH	ABILITATION		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		