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 05/14/2015

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 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff and family interviews, and record reviews, the facility failed to ensure a foam mat and a bed in lowest position were consistently implemented to prevent accidents and injury for 1 of 3 sampled residents with a history of falls(Resident # 1). The findings are: Review of Resident # 1 ' s record on 5/13/15 revealed she was originally admitted on 2/28/12 and readmitted on 7/31/14 after a hospitalization with diagnoses including Alzheimer ' s disease, Spinal Stenosis, Atrial Fibrillation, Psychosis NOS (not otherwise specified) & Abnormality of Gait. Review of Resident # 1 ' s most recent quarterly MDS dated 4/30/15 revealed she was assessed as having disorganized thinking, delusions and hallucinations, was totally dependent for transfers, eating and personal hygiene. The MDS also documented she had 1 fall with injury since her readmission. Review of a nursing note dated 4/22/15 at 2:30 PM revealed Resident # 1 requested to get out of bed to go outside for a visit, and the assigned CNA went to get assistance from another CNA. As the CNA ' s were walking back into the resident ' s room she was observed to roll out of	F 323	F -323 Free of Accident Hazzards/Supervision/Devices Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and or executed solely because it is required by the provisions of the State and Federal law. Resident #1 has all fall interventions including the bed in lowest position and a fall mat beside bed to provide adequate supervision and assistance devices to prevent accidents. All fall related incidents for the past ninety (90) days were reviewed. An audit was completed to ensure all fall interventions were in place as directed and Care Cards were updated. All care staff, nurses and nurse assistants	5/28/15

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

Electronically Signed | 05/27/2015

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F 323	Continued From page 1 bed onto the floor before the staff could stop the fall. Resident # 1 suffered a skin tear to left eyebrow, left arm and bottom of left foot. Review of follow up and investigation documentation related to the 4/22/15 fall revealed the facility placed the resident in a new bed in " low position and placed a fall mat alongside bed " to prevent injury and would continue to monitor resident. Review of Resident # 1 ' s current care plan dated 4/30/15 included a problem area of potential for falls with injury related to a history of falls, impaired decision making and poor safety awareness. A goal of " Resident will have no falls with injury through next review 7/30/15 " included approaches of " uses padded SRx2(side rails) for mobility and positioning, low bed with mat at bedside ... " Review of Resident # 1 ' s care guide, kept at the nursing station for guidance and reference, revealed the undated care guide did not include the use of a low bed or foam floor mat. The guide included " 3/4 side rails x 2 with pads and float heels " , but did not mention the updated plan after her 4/22/15 fall. Observations of Resident # 1 during the survey on 5/13/15 & 5/14/15 revealed the following: · 5/13/15 11:22 AM, 11:40 AM Resident in bed asleep with padded ¾ side rails up. Her bed was equipped with an air mattress and the bottom of the bed was approximately 1 foot from the floor. A foam mat was not on the floor beside her bed, and a mat was not observed in the room. · 5/13/15 12:20 PM CNA # 1 feeding resident, no foam mat was observed beside the bed or in the room, and the bed was approximately 1 foot from the floor. · 5/13/15 2:20 & 3:00 PM Resident sleeping in bed with padded ¾ side rails up. No foam mat	F 323	was in-serviced between May 14, 2015 and May 18, 2015 regarding procedures for fall interventions, reviewing the Care Card, and monitoring that necessary interventions are in place. The Unit Manager was in-serviced on May 14, 2015 regarding timely updating of the Care Cards and appropriate placement for care staff review. To ensure quality assurance, the Director of Nursing or designee will monitor for placement of current fall interventions twice daily x one week, then daily x four weeks. Fall interventions will continue to be monitored during Daily Administrative Room Rounds. Findings will be reviewed during the Quality Assurance Meeting for at least three consecutive meetings and every six months afterward. To ensure quality assurance, the Director of Nursing or designee will review all Care Cards for fall intervention accuracy weekly for six weeks and monthly for three months following. Findings will be reviewed during the Quality Assurance Meeting for at least three consecutive meetings and every six months afterward. All corrective action will be completed on or before May 28, 2015	

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F 323	Continued From page 2	F 323		

was observed in her room or beside her bed.
· 5/13/15 4:00 PM Resident sleeping in bed as above, with a foam mat placed on the left side of her bed. The bottom of the bed was approximately 6 " from the floor.
· 5/14/15 9:45 AM Resident sleeping in bed as noted above with a form mat placed on the left side of her bed. The bottom of the bed was approximately 6 " from the floor.
Interview with CNA # 1 on 5/14/15 at 12:45 PM revealed she does not typically care for Resident # 1, but does feed her at times. She further reported she removed the foam mat when she fed Resident # 1 on 5/13/15 and " forgot to put it back. "
Interview on 5/14/15 at 10:15 AM with CNA # 2, who was caring for Resident # 1 on 5/13/15, revealed she was aware of Resident # 1 having 1 fall and needing a low bed and foam mat beside her bed to prevent injury. CNA # 2 further reported " there is usually a mat in her room, but not always, it gets moved out and sometimes doesn ' t make it back in the room. " Staff # 2 further reported she did not notice the foam mat not being in place on the afternoon of 5/13/15. She further reported if questions arise about a resident ' s needs, CNA ' s refer to the care guide kept at the nurse ' s station, or ask a nurse for clarification.
Interviews with the Director of Nursing on 5/13/15 at approximately 3:30 PM revealed Resident # 1 had a history of being combative and refusing care at times due to confusion. She further reported she had not had a fall within the last year until 4/22/15. The DON further reported immediately after the fall her bed was changed to a bed that could be adjusted to the lowest position, with the bottom of bed frame being approximately 6 " from the floor, and a foam mat

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F 323	Continued From page 3	F 323		

was placed beside her bed to prevent injury. She further reported the foam mat could be removed during meals to allow staff space to move the bedside table to feed resident, but should be placed back beside the resident ' s bed. The DON also stated administrative staff do " care rounds to ensure interventions are in place. " The DON also reported the care guides located in the nurses ' stations were the references used by Nursing Assistants to ensure they understood individual care needs, and the guides should be kept up-to-date by the Unit Manager.

Interview on 5/14/15 at approximately 1:05 PM with the West Wing Unit Manager revealed she had updated the care guide, but failed to put it in the nurses ' station. The Unit Manager showed the surveyor an updated care guide dated 4/21/15 that included " floor mat and low bed " as interventions planned on that date. The Unit Manager further stated Resident # 1 ' s bed should be in the lowest position, approximately 6 " from the floor unless she is being supervised by staff.

Interview on 5/14/15 at 12:15 PM with the business office manager, who is assigned to monitor the implementation of Resident # 1 ' s care plan, revealed she checked daily in the morning around 8:30 AM to ensure the bed was in a low position, and the foam mat was in place, but does not check later in the day to ensure the devices are in place after lunch.

Interview with family member # 1 on 5/13/15 at 3:45 PM with a family member of concerning Resident # 1, who visits " 3-4 times per week " reported " for 1st couple of days after the fall in April her bed was low and the mat was on the floor, but after that it was back in regular height (2 feet from floor) and I don ' t always see that mat. "

Interview with family member # 2 on 5/14/15 at

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F 323	Continued From page 4 10:52 AM revealed he visits daily, and the resident ' s bed was not always in a low position. He further reported " the mat was usually stuck behind the bed when we come in, we usually come at meal times, but not always and the mat was not always on the floor. " Interview with the Facility Administrator on 5/14/15 at 1:30 PM revealed the facility had put interventions in place for Resident # 1 ' s safety which included the floor mat and having the bed in the lowest position. She further reported administrative staff did " care rounds " to ensure interventions were being consistently implemented. She further reported the facility maintenance man had put a foam mat in the resident ' s room at approximately 2:15 pm on 5/13/15, and Resident # 1 ' s family typically visited at meal times, and that is why the mat was not in place nor the bed was not in lowest position.	F 323		