

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

PRINTED: 06/22/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345204	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/27/2020
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NAME OF PROVIDER OR SUPPLIER STONECREEK HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801
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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 05/26/20 through 05/27/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# 70EJ11.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 05/26/2020 through 05/27/2020. There was one allegation investigated and it was substantiated and cited at F 880. Event ID # 70EJ11.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		6/5/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 06/04/2020
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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 880	<p>Continued From page 1</p> <p>conducted according to §483.70(e) and following accepted national standards;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv)When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and</p> <p>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of</p>	F 880			

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F 880	<p>Continued From page 2 infection.</p> <p>§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the facility's policies on "Handwashing/Hand Hygiene" and "Pandemic Viral, Infection Control Measures" the facility failed implement their policies to ensure staff performed hand hygiene when entering and exiting 4 of 4 resident rooms (Rooms #206, #214, #215 and #216). These failures occurred during a COVID-19 pandemic.</p> <p>The findings included:</p> <p>A review of the facility policy titled, "Handwashing/Hand Hygiene", revised on 04/2014 stated the facility considers hand hygiene the primary means to prevent the spread of infections. The interpretation and implementation of the policy directs all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use of an alcohol-based hand rub or alternatively soap and water for the following situations: after contact with objects in the immediate vicinity of the resident and after removing gloves.</p> <p>A review of the Emergency Preparedness and Response Policy and Procedure Manual revised 04/01/20 under section, "Pandemic Viral Illness, Infection Control Measures" the policy statement read in part: when viral illness is detected in the</p>	F 880	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiency herein. The plan of correction is completed in compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in the following plan of correction. The alleged deficiency cited have been or will be completed by the dates indicated.</p> <p>The facility maintains a Quality Assurance and Performance Improvement Committee that meets monthly to identify issues with respect to which quality assurance activities are necessary, develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>Corrective actions were immediately performed on 5/26/20. The door handle to exit hall 200 and door handle to dirty linen storage area were cleaned and sanitized.</p> <p>Staff Development Coordinator completed one on one education on 5/26/20 with housekeeping employee on proper hand hygiene procedure, use of an alcohol-based hand rub or alternatively soap and water after contact with objects in the immediate vicinity of the resident,</p>		

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F 880	<p>Continued From page 3</p> <p>geographic region of the facility, aggressive infection control measures will be implemented to prevent introduction of the virus to residents, staff and family. The policy interpretation and implementation read in part:</p> <p>1. Due to the increased risk of mortality from viral illness in the frail elderly, infection control measures to prevent the introduction or spread of the viral illnesses is a priority.</p> <p>2. Early prevention of viral illness outbreak consist of the following measures:</p> <p>a. Training clinical staff in the modes of transmission of the viral illness.</p> <p>b. Training of non-clinical staff standard infection control precautions (e.g., handwashing).</p> <p>1. On 05/26/20 at 10:22 AM Housekeeper (HK) #1 was observed in room #206. Room #206 was observed to have a sink with soap, water and paper towels available. While wearing gloves HK #1 touched multiple surface areas within the room including the remote control for the bed, the bed frame, and the nightstand. The bed linen had been removed and placed in a plastic bag. HK #1 removed and discarded his gloves, grabbed the bag of dirty linen and proceed to exit room #206. Hand hygiene was not performed by HK #1 and he was observed to use his bare hand to push the door handle to exit hall 200, and then touch the door handles to enter and exit the dirty linen storage area. Hand hygiene was still not performed by HK #1 and he was observed to use his bare hands to push the door handle to reenter hall 200.</p>	F 880	<p>after contact with objects and surfaces in the resident environment and after removing gloves.</p> <p>Residents who reside in the facility have the potential to be affected by the same deficient practice.</p> <p>Staff Development Coordinator initiated in-services on 5/26/20 and completed on 5/27/20 to all staff regarding standard infection control precautions on hand hygiene to ensure staff performed hand hygiene when entering and exiting resident rooms. All other staff who are otherwise out or on FMLA will complete the in-service prior to returning to work.</p> <p>An audit tool was developed to identify potential quality issues, this will include all staff e.g. nursing, housekeeping, therapy, dietary, activity, maintenance, administrative and all other staff performing hand hygiene before and after contact with the resident, after contact with blood, body fluids, or visibly contaminated surfaces, after contact with objects and surfaces in the resident's environment, after removing personal protective equipment and before performing procedure such an aseptic task. Audits will be completed weekly x 4 weeks, q 2 weeks x 2, then monthly x 2 months.</p> <p>As means of quality assurance, the Director of Nursing or designee shall report findings of audits and immediate corrective actions taken to the QAPI</p>		

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F 880	<p>Continued From page 4</p> <p>During an interview on 05/26/20 at 10:26 AM HK #1 explained room #206 was being deep cleaned and the process was to clean multiple surface areas in the room. HK #1 confirmed he did not perform hand hygiene after removing his gloves and then touched frequently used items in common areas of the facility which included door handles to exit and reenter hallway 200 and to enter and exit the dirty linen storage area. HK #1 was aware door handles were frequently used by staff and/or residents. When asked about the procedure of hand hygiene to prevent the spread of infection HK #1 explained he removed gloves when he exited a resident's room and would perform hand hygiene before entrance to a resident's room. HK #1 did not have an explanation of why he did not perform hand hygiene but was aware of the infection control policy, the pandemic and importance of hand hygiene to prevent the spread COVID-19.</p> <p>An observation made on 05/26/20 at 10:38 AM revealed an alcohol-based hand rub dispenser was attached to the wall by the exit door that was being used by HK #1.</p> <p>On 05/26/20 at 4:02 PM the Assistant Director of Nursing (ADON) explained she was also the Staff Development Coordinator and recently trained staff on proper handwashing techniques on 03/11/20. The ADON felt the incident of the HK not performing hand hygiene after touching frequently used items could potentially contaminate areas frequently used by staff and residents. The ADON reiterated staff should be performing hand hygiene prior to entering and exiting a resident's room; after touching resident items and before entering another residents room.</p>	F 880	<p>committee meetings. Further corrective action shall be planned and executed by the committee as warranted with follow-up reporting provided and reviewed to continually identify issues with respect to which quality assurance activities are necessary, develop and implement appropriate plans of action.</p>		

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F 880	Continued From page 5 During an interview on 05/27/20 at 9:22 AM the Director of Nursing explained when the HK removed his gloves, he should have washed his hands to have a clean hand to open doors. The DON thought the HK was nervous and overthinking what he was doing which caused him to forget to perform hand hygiene. 2. On 05/26/20 at 10:35 AM Nurse Aide (NA) #1 was observed to enter room #216 with no gloves and did not perform hand hygiene. Room #216 was observed to have a sink with soap, water and paper towels available. NA #1 was observed to remove a cup from room #216 which she picked up by the handle. NA #1 exited the room and proceed directly across the hall where an ice chest with a metal scoop was used to refill the cup with ice. NA #1 returned the cup and exited room #216 without performing hand hygiene. On 05/26/20 at 10:36 AM NA #1 was observed to enter room #214 with no gloves on and did not perform hand hygiene. Room #214 was observed to have a sink with soap, water and paper towels available. NA #1 was observed to remove a cup from room #214 which she picked up by the handle. NA #1 exited the room, walked to the ice chest and used the metal scoop to refill the cup with ice. NA #1 returned the cup and exited room #214 without performing hand hygiene. On 05/26/20 at 10:38 AM NA #1 was observed to enter room #215 with no gloves on and did not perform hand hygiene. Room #215 was observed to have a sink with soap, water and paper towels available. NA #1 was observed to remove a cup from room #215 which she picked up by the handle. NA #1 exited the room. An ice chest with	F 880			

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F 880	<p>Continued From page 6</p> <p>a metal scoop located outside room #215 was used to refill the cup with ice. NA #1 returned the cup and exited room #215 without performing hand hygiene.</p> <p>An observation made on 05/26/20 at 10:38 AM revealed an alcohol-based hand rub dispenser was attached to the wall by room #215 and was available for use.</p> <p>During an interview on 05/26/20 at 1:53 PM NA #1 confirmed she was not wearing gloves, nor did she perform hand hygiene before entrance and/or exit of each resident room observed during her hydration pass. NA #1 indicated recent training had been provided related to the pandemic and the importance of hand hygiene to prevent the spread of COVID-19. NA #1 stated hand hygiene was the facilities policy and procedure to prevent the spread of infection and she missed those steps today and described it as an oversight. NA #1 explained she knew it was wrong after she had exited the rooms observed and began to perform hand hygiene after contact with the cup handles used by individual residents and upon entrance and/or exit of each room.</p> <p>On 05/26/20 at 4:02 PM the Assistant Director of Nursing (ADON) explained she was also the Staff Development Coordinator and recently trained staff on proper handwashing techniques on 03/11/20. The ADON felt the incident of the NA not performing hand hygiene after touching frequently used items could potentially contaminate areas frequently used by staff and residents. The ADON reiterated staff should be performing hand hygiene prior to entering and exiting a resident's room; after touching resident items and before entering another residents</p>	F 880			

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F 880	Continued From page 7 room. During an interview on 05/27/20 at 9:22 AM the Director of Nursing explained NA staff should wash their hands before entering a resident's room and after touching a resident's water pitcher and before exiting the room. The DON thought the NA was nervous and overthinking what she was doing which caused her to forget to perform hand hygiene.	F 880			