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 11/19/2020

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

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E 000	Initial Comments An unannounced Recertification survey was conducted on 11/16/20 through 11/19/20. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID B24P11.	E 000		
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted from 11/16/20 through 11/19/20. Event ID# B24P11. 8 of the 8 complaint allegations were not substantiated. Event ID# B24P11.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F 656		12/17/20

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

Electronically Signed | 12/14/2020

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 656	Continued From page 1 provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive and individualized care plan for 2 of 20 residents (Resident #2 and Resident #37). Resident #2 had a diagnosis of Insulin Dependent Diabetes Mellitus (DMII) and was receiving insulin injections daily, and Resident #37 who utilized a left-hand edema glove. The findings included: 1. Resident #2 was admitted to the facility on 05/26/20 with diagnoses that included DMII. Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 08/24/20 revealed he was severely cognitively impaired and had a diagnosis of Diabetes Mellitus. Further review of the MDS indicated Resident #2 was coded as	F 656	The Statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in compliance of state and federal regulation 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 deficiencies cited have been or will be completed by the dates indicated. F-656 The Care Plan for Resident #2 was updated on 11/18/20 to address his diabetic needs. The Care Plan for Resident #37 was not indicated.	

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F 656	Continued From page 2 having received insulin injections for seven days of the look back period. Review of Resident #2's comprehensive plan of care revealed no plan of care for DMII or monitoring for the use of insulin. An interview with the MDS Nurse on 11/18/20 at 1:50 PM revealed Resident #2 had a diagnosis of DMII. She further indicated Resident #2 did not have a care plan regarding his diabetes or the use of insulin. There should have been a care plan developed for Resident #2. An interview conducted with the Director of Nursing (DON) on 11/19/20 at 11:55 AM revealed she was not aware Resident #2 did not have a care plan for Diabetes. She stated Resident #2 should have had a care plan for Diabetes. 2. Resident #37 was admitted to the facility on 11/14/18 with diagnosis including muscle weakness, cognitive function following cerebral infarction, contracture left hip, edema, and major depressive disorder. Review of the Minimum Data Set (MDS) dated 10/07/20 revealed Resident #37 was not cognitively intact. The MDS revealed Resident #37 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. Resident #37 was coded as having an upper extremity impairment to her left side. Review of Resident #37 comprehensive care plan dated revealed no interventions for the use of and edema glove. Review of Resident #37 physician order dated	F 656	100% audit of Care Plans for residents with a diagnosis was completed on 11/18/20 and for residents with active restorative orders on 12/02/20. The interdisciplinary team was in-service on 12/9/20 regarding Care Plans for active problems, quarterly review and updates as the resident's condition warrants. Regional Clinical Manager will audit 50% of Care Plans for residents with diabetes restorative programs weekly for 4 weeks, then monthly for 3 months. Results of audits will be presented to the the facility's Quality Assurance Committee for review and recommendations monthly for 3 months and thereafter as necessary.	

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F 656	Continued From page 3 05/29/19 revealed the edema glove was to be applied in the morning and removed at night. Review of the facility's resident contracture list dated located on the med cart dated 11/17/20 revealed Resident #37 had a contracture of her left hand with the orthotic use of a left upper extremity (LUE) edema glove. The resident contracture list further identified resident #37 as being non-compliant with the use of the left extremity glove. An interview with Nurse #2 on 11/18/20 revealed he was unaware of Resident #37 having a left upper extremity contracture and was also unaware of her use of an edema glove. An interview with the Director of Nursing (DON) was conducted on 11/19/20 at 11:57 am. She indicated that she should have been a care plan for the use of the resident #37 edema glove, but the facility had not care planned Resident #37 upper extremity impairment. An interview with the Administrator conducted on 11/19/20 at 12:22 pm revealed Resident #37 edema glove should have been care planned.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 684		12/17/20

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F 684	Continued From page 4 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to document therapy recommended restorative care and discontinued a therapy recommended left resting hand splint without an order for 1 of 6 residents (Resident #37) reviewed for range of motion (ROM). The findings included: Resident #37 was admitted to the facility on 11/14/18 with diagnosis including muscle weakness, cognitive function following cerebral infarction, contracture of left hip, edema, and major depressive disorder. Review of the quarterly Minimum Data Set (MDS) dated 10/07/20 revealed Resident #37 required extensive assistance with bed mobility, dressing, toileting, and personal hygiene. Resident #37 had an upper extremity impairment to her left side and was coded as being cognitively impaired. Review of Resident #37 restorative plan revealed an evaluation date of 2/18/20 and last treatment day of 2/25/20. The restorative plan identified a "problem" of contracture. The issues to be addressed included 1) passive ROM to left upper extremity with stretching and 2) splinting to left upper extremity as tolerated and a frequency of 6 time per week for a duration of 12 weeks. The restorative begin date was left blank on the restorative plan. Review of Occupational Therapy Encounter Note dated 02/25/20 included a summary that stated Resident #37 had passive range of motion	F 684	F-684 Resident #37 was discussed in PAR meeting on 12/02/20 and restorative program was deemed unnecessary at this time due to resident's desire not to comply with the program. IDT reviewed 100% of the restorative caseload. All orders and care plans evaluated between the dates of 12/2/20-12/3/20. The interdisciplinary team was in-serviced on 12/9/20 regarding restorative orders, weekly review and discontinuation orders and daily documentation. Regional Clinical Manager will audit 50% of restorative documentation weekly for 4 weeks, then monthly for 2 months. Results of audits will be presented to the facility's Quality Assurance Committee for review and recommendations monthly for 3 months and thereafter as necessary.	

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F 684	Continued From page 5	F 684		

performed to her upper left extremities to include her hand, finger and wrist to increase ROM for splinting. The encounter further revealed OT donned and doffed left upper extremity resting hand splint dependently and was able to tolerate splinting for 6 hours.

Medical record review from 02/25/20 through 11/18/20 revealed no documentation of Resident #37 receiving restorative care for passive ROM or splinting to left upper extremity.

An interview with the Restorative Nurse on 11/18/20 at 11:31 am revealed she became aware of Resident #37's restorative needs by the therapy department. She stated that she ensured restorative staff were aware of the plan put into place and provided training. The Restorative nurse stated Resident #37 was non-compliant with the use of the splint and she independently discontinued its use. She stated she had the ability to discontinue the plan by removing it from the electronic system. She indicated the therapy department was made aware of the resident's refusal of splinting and could not recall any other method attempted for the Residents left hand contracture. Restorative staff were to document restorative care to include resident refusals. The Restorative Nurse stated nursing staff were to document restorative care within the facilities electronic medical record. The Restorative Nurse could not identify the date in which she discontinued Resident #37's left hand resting hand splint.

Interview with the Director of Nursing (DON) on 11/19/20 at 11:48 am revealed restorative care should be documented and include resident non-compliance with therapy recommended

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F 684	Continued From page 6 services. She stated a resident's non-compliance should be communicated to therapy to determine if re-evaluation was recommended. Any changes in restorative care or discontinuation of splinting should be completed by OT or the physician through an order. An interview with the Administrator on 11/19/20 at 12:22 pm revealed a contracture device would need to be discontinued by the therapy department or through a physician order and restorative care should be documented.	F 684		