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 06/29/2022

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
E 000	Initial Comments An unannounced recertification survey was conducted on 6/26/2022 through 6/29/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #IBUS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint survey was conducted from 6/26/2022 through 6/29/2022. All 7 complaint allegations were unsubstantiated. Intake # NC00188762, NC00188682, NC00188832. Event ID# IBUS11.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		7/6/22

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

Electronically Signed | 07/21/2022

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F 657	Continued From page 1 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident representative and staff interviews, the facility failed to conduct and include the resident's representative in care plan meetings for 1 of 2 residents reviewed for care plan meetings (Resident #59). The findings included: Resident #59 was admitted to the facility on 7/14/2021. A quarterly MDS assessment dated 6/1/2022 revealed Resident #59 was moderately cognitively impaired. The care conference log in Resident #59's electronic medical record was reviewed and revealed the only care conference documented was on 7/21/2021. The care plan meeting coordination binder was reviewed from August 2021 through June 2022 and did not reveal a care plan meeting had been held for Resident #59 during that time frame. During an interview with Resident #59's representative on 6/26/2022 at 3:25 PM, Resident #59's Representative stated it had been a long time since he had been invited to a care plan meeting and could not recall when a meeting had last been conducted. Resident #59's representative indicated he would like to attend	F 657	The Responsible Party and resident #59 were invited to attend a care plan meeting regarding resident #59 on 6/28/2022 by the Social Worker. This meeting was held on 7/6/202 per RP choice. 100% audit of all in house residents was conducted on 7/1/2022 by Social Worker to ensure the resident/or resident representative had been invited to attend and participate in the comprehensive or quarterly care plan meeting. Any concerns identified were addressed immediately with an invitation to attend a care plan meeting. The Minimum Data Set Coordinator, and Social Worker were in-serviced by the Regional Minimum Data Set Manager and Administrator on 7/1/2022. This in-service reviewed was the F657 tag The Administrator or designee will audit all quarterly care plans to ensure that the resident and/or resident representative have been invited to attend a care plan meeting. Facility will continue to audit: four care plan meetings weekly x 4 weeks, then two care plan meetings x 4 weeks, then one care plan once a week x 4 weeks.	

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F 657	Continued From page 2 the meetings to discuss Resident #59's plan of care. An interview with the Social Worker (SW) on 6/28/2022 at 2:23 PM revealed care plan meetings were conducted quarterly. The SW further revealed invitations were mailed to family members prior to the month the care plan meeting would be held, and family members would call the facility to schedule the meeting. The SW stated the receptionist kept a copy of the care plan meeting invitation letters and the monthly care plan meetings that had been held in the past at the front desk. A follow up interview with the SW and the facility Administrator on 6/28/2022 at 3:04 PM revealed the SW received a monthly calendar from the Minimum Data Set (MDS) Coordinator for residents that were due for MDS assessments the upcoming month, and she scheduled care plan meetings based off that calendar. The SW stated she did not realize Resident #59 had not had a care plan meeting since 7/21/2021 and was not sure why they had been missed. The Administrator stated the reason the care plan meetings may have been missed was because Resident #59 had multiple discharges and readmissions between August 2021 and February 2022. The Administrator revealed she thought when the calendar was written up by the MDS coordinator, Resident #59 was probably not in the facility and was added to the calendar the MDS coordinator had in her possession when he readmitted but not to the one the SW already had in her possession. A follow up interview with the Administrator on 6/29/2022 at 3:34 PM revealed care plan	F 657	The Administrator or designee will bring the audit results to the Quality Assurance Meeting monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the training and observations to determine if continued auditing is necessary to maintain compliance. Date of completion 7/6/2022	

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F 657	Continued From page 3 meetings should be held quarterly regardless of the residents' admissions and discharges within that quarter and family members should be invited to care plan meetings.	F 657		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by failure to administer 2 medications according to the Physician's orders. These errors constituted 2 out of 30 opportunities, resulting in a medication error rate of 6.67% for 2 of 6 residents observed during medication administration pass (Resident #67 and Resident #28). The findings included: 1. Resident #67 was readmitted to the facility on 12/7/2020. An observation was made on 6/29/2022 at 8:21 AM of Nurse #1 while she prepared and administered Resident #67's medications. Nurse #1 did look at the Medication Administration Record (MAR) while she prepared the medications which included Vitamin D (supplemental medication) that she pulled from the house stock. Nurse #1 was observed to prepare 2 Vitamin D 1000 international units (IU)	F 759	Nurse #1 was immediately educated on the 6 rights of medication administration by the Director of Nursing. Residents #28 and #67 were given the additional medications to complete the administration. The resident, Responsible party and the Medical Provider were notified of the error on 6/29/22 by the Director of Nursing. 100% Medication pass observation was completed by 7/6/22 for all licensed nurses and medication aides by the Director of Nursing. Any error observed was corrected and notification provided to the resident, responsible part and the Medical Provider. There were no errors observed. 100% in service on the 6 rights of medication administration was initiated on 6/30/2022 by the Director of Nursing for all licensed nurses and medication aides. Any licensed nurse or medication aide who did not receive the in service by 7/6/2022, will not be allowed to work until	7/8/22

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F 759	Continued From page 4 tablets to equal 2000 IU. Nurse #1 administered the 2 Vitamin D 1000 IU tablets to equal 2000 IU to Resident #67. Resident #67's Physician's orders were reviewed and revealed an order dated 12/7/2020 for Vitamin D 2000IU- give 2 tablets (4000 IU) by mouth every day. An interview along with an observation of Resident #67's MAR and Physician's orders with Nurse #1 on 6/29/2022 at 1:46 PM revealed Nurse #1 saw the order for Vitamin D 2000 IU give 2 tablets to equal 4000 IU. Nurse #1 stated the reason she had only given Resident #67 2000 IU of the Vitamin D was because she misread the order and thought the order was for a total of 2000 IU. An interview was conducted with the Director of Nursing (DON) on 6/29/2022 at 2:42 PM which revealed nurses needed to ensure the medication that was being administered was the accurate dose prior to administration of the medication to the residents. 2. Resident #28 was admitted to the facility on 9/19/2019 with diagnoses which included Vitamin D deficiency. An observation was made on 6/29/2022 at 8:36 AM of Nurse #1 while she prepared and administered Resident #28's medications. Nurse #1 did look at the MAR while she prepared the medications which included Vitamin D that she pulled from the house stock. Nurse #1 was observed to prepare 2 tablets of Vitamin D 1000 IU to equal 2000 IU. Nurse #1 administered the 2 tablets of Vitamin D 1000 IU to equal 2000 IU to	F 759	the in service has been completed. The Director of Nursing/designee will complete 5 med pass observations weekly x 4 weeks, then 3 med pass observations weekly x 4 then one med pass observation weekly x 4 weeks. The Director of Nursing or designee will bring the medication pass observation audits to the Quality Assurance Committee monthly x 3 months. At that time, the QAPI committee will evaluate the effectiveness of the training and observations to determine if continued auditing is necessary to maintain compliance. Date of completion 7/8/2022	

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F 759	Continued From page 5 Resident #28. Resident #28's Physician's orders were reviewed and revealed an order dated 9/10/2019 for Vitamin D 2000 IU tablet- administer two tablets (4000 IU) by mouth daily. An interview along with an observation of Resident #28's MAR and Physician's orders with Nurse #1 on 6/29/2022 at 1:46 PM revealed Nurse #1 saw the order for Vitamin D 2000 IU give 2 tablets to equal 4000 IU. Nurse #1 stated the reason she had only given Resident #28 2000 IU of the Vitamin D was because she misread the order and thought the order was for a total of 2000 IU. An interview was conducted with the DON on 6/29/2022 at 2:42 PM which revealed nurses needed to ensure the medication that was being administered was the accurate dose prior to administration of the medication to the residents.	F 759		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 812		7/5/22

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F 812	Continued From page 6 (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to store canned and frozen food products off the floor for 2 of 3 food storage areas (the dry storage room and walk-in freezer). This practice had the potential to affect food served to residents. The findings included: 1. An observation of the dry storage room 6/26/22 at 9:55 AM revealed 1 full case (6 cans) of # 10 size canned turnip greens and 1 full case of # 10 size canned spaghetti sauce on the floor. Multiple boxes of various dry storage food items were stacked on top of the full case of turnip greens and full case of spaghetti sauce. 2. An observation of the walk-in freezer 6/26/22 at 9:58 AM revealed 1 case of bread stored on the floor of the freezer. The cook reported during this time, that the stock was delivered on 6/24/22 and that a dietary staff member was usually assigned to put the stock up. The Certified Dietary Manager (CDM) was interviewed on 6/28/22 at 9:24 AM revealed that the food was delivered on Friday between 3 PM and 7 PM. The CDM stated that she assigned a dietary staff to put the stock up and that person was supposed to put up the stock when it arrived on 6/24/22.	F 812	The food improperly stored on the floor in the freezer and dry storage room was removed on 6/26/22 by the Dietary Manager An audit of the kitchen and storage rooms was conducted on 6/26/22 by the Dietary Manager for any improperly stored items. No additional items were found The Dietary Manager was in-serviced by the Administrator on 6/27/2022 for proper storage for all food items. The Dietary Manager in-serviced all dietary aides and cooks on proper storage of food in the kitchen and storage rooms on 6/27/2022. Any dietary aide or cook who did not receive the in-service will not be allowed to work after 7/1/2022 until the in-service has been completed. The Dietary Manager or designee will audit the freezer and dry storage room to ensure stock has been put away and not improperly stored. This audit will be conducted twice weekly x 4 weeks, then weekly for 4 weeks and then once during the third month. The Dietary Manager will be responsible for bringing these audit results to the	

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F 812	Continued From page 7 On 6/29/22 at 3:39 PM the Administrator reported that the dietary staff should have put the stock up before they left their shift and food supplies should never be stored on the floor.	F 812	Quality Assurance Meeting x 3 months where they will be reviewed for compliance. Proper food storage/Safe food handling will be added to orientation process. Date of completion 7/5/2022.	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345204	A. BUILDING: _____ B. WING _____	6/29/2022

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 641	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 3 residents reviewed for discharge (Resident #85). The findings included: Resident #85 was admitted to the facility on 3/24/2022 for aftercare following a joint replacement surgery. A progress note dated 4/6/2022 revealed Resident #85 had been discharged to her home. A discharge Minimum Data Set (MDS) assessment dated 4/6/2022 revealed the discharge was planned, return was not anticipated and the discharge status for Resident #85 was coded as acute hospital. An interview with the Social Worker on 6/28/2022 at 2:23 PM revealed Resident #59 was discharged to her home not the hospital and the discharge was planned. An interview with the MDS coordinator on 6/28/2022 at 3:57 PM revealed Resident #59 discharged home on 4/6/2022. The MDS coordinator further revealed she had coded Resident #59's discharge status as a hospital discharge and it should have been coded instead as discharge to home. The MDS coordinator stated she was not sure why it was documented in error. An interview with the Administrator on 6/29/2022 at 3:33 PM revealed all MDS assessments needed to be accurate and should be double checked for accuracy prior to submitting them.

The above isolated deficiencies pose no actual harm to the residents