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 09/03/2015

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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigations. Event ID ZKKJ11.	F 000		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review	F 278	Disclaimer Clause:	9/24/15

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

Electronically Signed | 09/24/2015

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F 278	Continued From page 1 and staff interviews, the facility failed to accurately assess a resident's dental status on the annual Minimum Data Set (MDS) assessment for 1 of 2 residents (Resident # 39). Findings included: Resident #39 was admitted to the facility on 01/12/07 with diagnoses of Alzheimer's Disease and chronic obstructive pulmonary disease. Review of the annual MDS dated 04/14/15 revealed Resident #39 was moderately cognitively impaired and required extensive assistance with activities of daily living. There were no dental/oral concerns noted on this annual assessment with no development of a care plan. 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 visualizing teeth of the upper jaw. An interview was conducted with the Director of Nursing (DON) on 09/03/15 at 12:19 PM. The DON stated her expectation was information recorded in the MDS assessments would be accurate so a proper care plan could be developed.	F 278	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. Corrective action accomplished for resident that was affected. Resident #39 received physical examination of his oral cavity and a modification of MDS for this resident with an ARD of 4/14/15 was completed to include accurate coding for and dental 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 cross referenced with most previous answer from comprehensive assessment. All residents that are currently scheduled to receive a comprehensive MDS assessment within next month (9/18/15 - 10/18/15) will have such completed in a timely and accurate manner. Any residents that require a modification of most recent comprehensive assessment will have such modification completed to accurately reflect dental status and	

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F 278	Continued From page 2	F 278	transmitted to state database by 9/23/15. Measures / systemic changes made to ensure no future reoccurrence. All personnel currently employed in a position which requires completion of Section L on MDS¿s have received education regarding proper coding techniques by Corporate Director of MDS / Compliance Services on 9/3/15. All personnel have been able to provide appropriate verbal responses related to questions regarding coding of Section L. Monitoring of corrective actions and ensuring such actions are sustained. An audit will be completed weekly for four weeks to ensure that all residents, requiring a comprehensive MDS per OBRA schedule, are appropriately coded by at least 2 persons employed in a position that requires completion of MDS (who did not complete Section L on MDS being reviewed) these audits will be reviewed at the monthly QAPI meeting. If all audits are in compliance, the QAPI committee will direct ongoing audits and review of at least 10 MDS¿s , not to be less than monthly for 6 months. The QAPI committee will direct course of action thereafter.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		9/24/15

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F 441	Continued From page 3 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to disinfect a blood glucose meter, a machine used to check blood sugar, according to manufacturer's recommendations for 1 of 1 resident observed for a blood sugar check (Resident #57).	F 441	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	

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F 441	Continued From page 4 The findings included: Review of the blood glucose meter manufacturer's instructions indicated the blood glucose meter should be disinfected with a disinfectant wipe after each use, the meter should be wiped on all surfaces until completely wet with the disinfectant wipe and the meter should remain wet for 1 minute before the next use. On 09/02/15 at 4:19 PM during observation of medication administration Nurse #1 removed a blood glucose meter from the medication cart and wiped it with an alcohol wipe, gathered her supplies and began walking to Resident #57's room to perform a blood glucose finger stick. Nurse #1 was stopped by the surveyor before entering Resident #57's room to perform the finger stick. An interview was conducted on 09/02/15 at 4:20 PM with Nurse #1. She stated she cleaned the blood glucose meter with an alcohol wipe between residents. She stated there were disinfectant wipes in the medication cart that could be used to clean the blood glucose meter but she didn't use them because they caused the monitor to be too wet. Nurse #1 further stated she was not aware of what the facility policy was for cleaning blood glucose meters. During an interview conducted on 09/02/15 at 4:22 PM with the Director of Nursing (DON) she stated it was her expectation for blood glucose meters be cleaned with the disinfectant wipes located in each medication cart after each use. The DON stated the blood glucose meter should be thoroughly wiped on all surfaces with the disinfectant wipe and remain visibly wet for 1 minute after each use.	F 441	prepared and or executed solely because it is required by the provisions of the State and Federal law. Corrective action accomplished for resident that was affected. An individual glucometer was provided for 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 will be disinfected after each use per manufacturer¿s instructions with all nursing personnel. Upon discharge from 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 on 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.	

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F 441	Continued From page 5	F 441	All licensed nursing personnel currently employed received education regarding proper disinfection of glucometers by the Director of Nursing, the Staff Development Coordinator and the Weekend Coordinator between 9/18/15 and 9/21/15. The licensed nursing personnel were able to provide verbal response with positive answers regarding disinfection techniques. This education included: The Policy & Procedure regarding maintaining individualized glucometers for all residents requiring blood glucose monitoring as well as written instructions for proper disinfection of glucometers per manufacturer¿s recommendations. All licensed nurses hired after 9/21/15 will receive the same information during orientation period. All residents admitted after 9/23/15 will receive individualized glucometers that will be labeled with resident name and will be disinfected per manufacturer¿s recommendations. Monitoring of corrective actions and ensuring such actions are sustained. An audit will be completed weekly for four weeks to ensure that all residents that require glucose monitoring have an individualized glucometer that is properly stored and labeled. These audits will be conducted by the DON(or designee) and will be reviewed at monthly QAPI Meeting. If all audits are in compliance, the QAPI Committee will direct ongoing audits and review, not to be less than monthly for 6 months. QAPI committee will direct course of action thereafter.	

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