PRINTED: 04/21/2011 FORM APPROVED OMB NO. 0938-0391

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL		PLE CONSTRUCTION	COMPLE	TED
	ļ	345204	B. WIN	G			C 3/2011
	ROVIDER OR SUPPLIER REEK HEALTH AND SUMMARY STA	REHABILITATION TEMENT OF DEFICIENCIES	ID	45	EET ADDRESS, CITY, STATE, ZIP CODE IS VICTORIA ROAD SHEVILLE, NC 28801 PROVIDER'S PLAN OF CORREC		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE OPRIATE	COMPLETION DATE
F 225 SS=D	The facility must no been found guilty or mistreating residen had a finding entere registry concerning of residents or mise and report any know court of law against indicate unfitness for other facility staff to or licensing authority. The facility must en involving mistreatm including Injuries of misappropriation of immediately to the to other officials in a through established State survey and control of the facility must have a survey and co	erification agency). TolvIDUALS It employ individuals who have f abusing, neglecting, or its by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; whedge it has of actions by a standard and an employee, which would or service as a nurse aide or the State nurse aide registry ties. Issure that all alleged violations ent, neglect, or abuse, unknown source and resident property are reported administrator of the facility and accordance with State law if procedures (including to the ertification agency). Inve evidence that all alleged ughly investigated, and must ential abuse while the rogress.	F 2	25	***This Plan of Correction constitution allegation of compliance deficiencies cited. However, submof this Plan of Correction is not at admission that a deficiency exists one was cited correctly. This Plan Correction is submitted to meet requirements established by statifederal law.*** -24 hour and 5 day working report been submitted to the state agent Resident 1. -Audit of incident reports for the days was completed to check for unknown source. No other Resid were found to be affected. All enin-serviced on abuse, including in unknown origin, and abuse report procedures. -DON or designee will review all it reports and investigate any injuriounknown origin on an ongoing baths of the property of the property of the network of the property of the network of the	for the interest of the intere	- 5/5/2011
ARORATORY	A DIBECTOR'S OB BROVE	 DERISTIPPTIER DEPRESENTATIVE'S SIGN	ATHRE		TITI F		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sergeguards 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. Signature Date: 5-2-11

FORM CMS-2567(02-99) Provious Versions Obsolute

Event ID: 5FIE11

Facility ID: 923521 RECEI Vicinitation sheet Page 1 of 12

MAY 1 0 2011

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	AULTIP ILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	TED
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<u></u>		345204		<u>''-</u>		04/1	3/2011
	PROVIDER OR SUPPLIER CREEK HEALTH AND	REHABILITATION		45	EET ADDRESS, CITY, STATE, ZIP CODE 55 VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	This REQUIREMEI by: Based on staff Inter record review, the for unknown source twenty-four hours for with a broken leg (for The findings are: Resident # 1 was a 05/27/10 with diagrate degenerative joint of peripheral neuropal Set dated 02/17/11 short and long term moderately impaire decision making. Review of her medical had had a fracture leg at another facilits subsequent ampute 07/06/10 her physician at the preprogress notes, "Sepontaneous fracture of the control of the control of the complaint of pain due to decide a spart of 04/09/11 Nursing A resident up for the complaint of pain due to decide a spart of 04/09/11 short and the preproximately 7:20 she did not notice a resident's left leg arcomplaint of pain due to decide a spart of 04/09/11 documented that the state of the complaint of pain due to decide a spart of 04/09/11 documented that the state of the complaint of pain due to decide a spart of 04/09/11 documented that the state of the complaint of pain due to decide a spart of 04/09/11 documented that the state of the complaint of pain due to decide a spart of 04/09/11 documented that the control of the complaint of pain due to decide a spart of 04/09/11 documented that the control of the con	NT Is not met as evidenced eviews, and medical and facility facility failed to report an injury to to the state agency within for one (1) of one (1) resident Resident # 1). admitted to the facility on moses of dementia, disease, osteoporosis, and athy. The latest Minimum Data is revealed the resident had memory problems and was ad in cognitive skills for daily desident # 1 required extensive with activities of daily living. lical record revealed that she of unknown source of her right lity prior to this admission with a ation of the right leg. On clan, who had been her evious facility, wrote in his She is at increased risk for		225			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345204	B. WING	, <u> </u>	1	C 3/2011
	PROVIDER OR SUPPLIER CREEK HEALTH AND	REHABILITATION	45	REET ADDRESS, CITY, STATE, ZIP CODE 55 VICTORIA ROAD ISHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 225	beneath the resided day shift, and the repain nor exhibit any transferred the resi approximately 1:30 resident exhibited in not notice anything leg. According to nursing recorded as part of went to the resident p.m. to perform incresident up for dinning pulled the covers beas if to assist her. Seleg was underneath right leg. The resident was a family were notified transported to the increvealed her left leg. On 04/12/11 at 12:3 physician was intensitated the resident fracture of her right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right under his care, and spontaneous fracture of the right legal to the right leg	nt's legs three times during the esident did not complain of y signs of distress. NA # 1 ident back to bed at p.m., stating again the no signs of pain and she did wrong with the resident's left may note and staff statements a facility investigation, NA # 2 it's room at approximately 4:30 continence care and get the ner. She stated that as she mack, the resident was moving she noticed the resident's left in the amputated stump of her dent began to scream with enoticed her ankle was turned by the noticed her ankle was turned by NA # 2 called the nurse. In the resident was moving seesesed, the physician and hand the resident was mospital. Hospital records g was fractured. 30 p.m. the resident's viewed by telephone. He had a history of spontaneous a leg at another facility while the considered this a lare related to her severe tated it was impossible to know and occurred as the resident's thy could mask the pain.	F 225			

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONS DING	STRUCTION	(X3) DATE SU COMPLE		
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NAME OF F	PROVIDER OR SUPPLIER	345204		CTDEST ADD	DRESS, CITY, STATE, ZIP CODE	04/ <u>1</u> -	3/2011	
	REEK HEALTH AND	REHABILITATION		455 VICTO	DRIA ROAD LLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC EACH CORRECTIVE ACTION SHO OSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 225	hospital. She state she did not know he the Unit Manager to the medical record on 04/10/11 at app began her investigated she continued Monday, 04/11/11 the resident that dathe family alleged sesident's leg on pure assured the family incident. The Admil investigation was of the same of the sesident's leg on pure sesident.	d the Unit Manager told her ow it had happened. She told to document what she knew in The Administrator stated that roximately 1:30 p.m. she ation by reading the resident's attempting to contact the staff the resident on 04/09/11. She at the investigation on and spoke with the family of any. The Administrator stated comeone may have broken the urpose. She stated that she that she was investigating the nistrator also stated her ngoing as she was still act some staff members for	Fí	225				
F 226 \$S=D	unknown source, be the state agency we because she considered accident, based on medical record, the osteoporosis, and if the Administrator is twenty-four hour areagency for an injury there were signs on there was neither in 483.13(c) DEVELO ABUSE/NEGLECT. The facility must depolicies and proced mistreatment, negline accidents and procedulate and	P/IMPLMENT , ETC POLICIES evelop and implement written	Fí	been Resid Aud days	nour and 5 day working repo n submitted to the state age dent 1. dit of incident reports for th was completed to check for nknown origin.	ncy for e last 30		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	TED
		345204	B. Wil	۷G _			C 3/2011
	ROVIDER OR SUPPLIER		!	4!	EET ADDRESS, CITY, STATE, ZIP CODE 55 VICTORIA ROAD SHEVILLE, NC 28801	<u> </u>	0/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	IULD BE	(X5) COMPLETION DATE
F 226	This REQUIREMENT by: Based on staff Intel record review, and facility failed to report to the state agency one (1) of one (1) re (Resident # 1). The findings are: A policy provided by and entitled "Abuse" "The Director of Nusurvey, certification proper authorities of involving mistreatm including injuries of misappropriation of hours. 4. The resu working days of the violation is verified, that was taken." Resident # 1 was a 05/27/10 with diagn degenerative joint of peripheral neuropal Set dated 02/17/11 short and long term moderately impaire decision making. Re to total assistance verified that had a fracture of	NT is not met as evidenced eviews, medical and facility facility policy review, the cort an injury of unknown origin within twenty-four hours for esident with a broken leg of the facility dated 01/01/11 ether read in part: rsing will inform the state incensing agencies and other of: 2. All alleged violations ent, neglect, or abuse, unknown source, and resident property within 24 its of all investigations within 5 incident, and if the alleged appropriate corrective action different incident, and if the alleged appropriate corrective action different incident, and if the alleged appropriate corrective action different incident, and if the alleged appropriate corrective action different incident, and if the alleged appropriate corrective action different incident, and if the alleged appropriate corrective action different incident incomplete incomp	F	226	No other Residents were found to affected. All employees in-service abuse, including injuries of unknoorigin, and abuse reporting proces. - DON or designee will review all reports and investigate any injuricunknown origin on an ongoing base. -Findings from this ongoing system change will be reported at the new Quarterly QA meeting for the new months.	ed on own edures. incident es of asis. matic ext	5/5/2011
	red at shother tacilli	y prior to this admission with a		ŀ			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG	(X3) DATE SU COMPLE	
		345204	B. Wi			1	0
		340204				<u> 04/1-</u>	3/20 <u>11</u>
	PROVIDER OR SUPPLIER CREEK HEALTH AND	REHABILITATION		4	REET ADDRESS, CITY, STATE, ZIP CODE 55 VICTORIA HOAD ASHEVILLE, NC 28801		
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULO BE	(X6) COMPLETION DATE
F 226	Continued From pa	ge 5	F	226			
. 220	subsequent ampute 07/06/10 her physic physician at the pre progress notes, "Si spontaneous fractu	atton of the right leg. On clan, who had been her evious facility, wrote in his ne is at increased risk for res."	•	L LO	·		
	recorded as part of 04/09/11 Nursing A resident up for the approximately 7:20 she did not notice a resident's left leg all complaint of pain d# 1 documented the footrests were in us beneath the resident day shift, and the repain nor exhibit any transferred the resident exhibited	g notes and staff statements a facility investigation, on ssistant (NA) # 1 got the day into her wheelchair at a.m. She documented that anything wrong with the ad the resident had no uring the day. Licensed Nurse at the resident's wheelchair are, pillows were placed at's legs three times during the esident did not complain of signs of distress. NA # 1 dent back to bed at p.m., stating again the o signs of pain and she did wrong with the resident's left					
	recorded as part of went to the resident p.m. to perform incoresident up for dinn pulled the covers bas if to assist her. Sieg was underneath right leg. The resident was as family were notified	g notes and staff statements a facility investigation, NA # 2 is room at approximately 4:30 onlinence care and get the er. She stated that as she ack, the resident was moving the noticed the resident's left the amputated stump of her ent began to scream with noticed her ankle was turned g. NA # 2 called the nurse. ssessed, the physician and and the resident was ospital. Hospital records					·

		A MEDIOAID GETTTICEG	(Val. b)	0 (I T	IDLE CONSTRUCTION	(X3) DATE SU	IRVEY
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUI		IPLE CONSTRUCTION IG	COMPLE	TED
			B. WII			1	C
		345204	J. 7711	·~-		04/1	3/2011
NAME OF F	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
STONEC	REEK HEALTH AND	REHABILITATION			ISS VICTORIA ROAD ASHEVILLE, NC 28801		i
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	TION	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	ULD BE	(X5) COMPLETION DATE
1/0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				DEFICIENCY		
F 226	Continued From pa	ge 6	F	226			
	revealed her left leg	y was fractured.					
	On 04/12/11 at 12:3	30 p.m. the resident's					
		viewed by telephone. He			İ		
!	stated the resident	had a history of spontaneous					
		leg at another facility while					
		he considered this a					
		re related to her severe ated it was Impossible to know					
		ad occurred as the resident's					
		thy could mask the pain.					
	On 04/12/11 at 12:4	12 n.m. the facility					
		nterviewed. She stated she				ļ	
		esident's broken leg on					
		esident was sent to the					
		d the Unit Manager told her					
		ow it had happened. She told					
		document what she knew in					
		The Administrator stated that oximately 1:30 p.m. she					
		ition by reading the resident's				İ	
İ		attempting to contact the staff					
	who had cared for t	he resident on 04/09/11. She					
		d her investigation on					
		and spoke with the family of				,	
		y. The Administrator stated					
		omeone may have broken the from the fro					
		hat she was investigating the					
		nistrator also stated her					,
	investigation was or	ngoing as she was still					
		ct some staff members for					
	interview on 04/13/1	11.				i	
ĺ	The Administrator re	eviewed the facility policy					
ì		stated that this was an injury					
	of unknown source,	but she did not file a report					
	with the state agend	y within twenty-four hours					1

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE S COMPLI	
		345204	A. BUILDII B. WING _			C 3/2011
1	PROVIDER OR SUPPLIER CREEK HEALTH AND		1 4	REET AODRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	1 0.0.	OILO I I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 226 F 354 SS=C	because she cons accident, based or medical record, the osteoporosis, and The Administrator twenty-four hour are agency for a serior only if there were and that there was 483.30(b) WAIVEF FULL-TIME DON Except when waive this section, the faregistered nurse for a day, 7 days a ween section, the faregistered nurse for aursing on a full through the faregistered nurse for a furnity of 60 or This REQUIREME by: Based on staff interedocumentation reverse a Registered Nurse for at least 35 hour The findings are: An on site visit was began at 8:45 a.m.	Idered this an unwitnessed in her reading of the resident's e resident's diagnosis of her history of previous fracture. It is the would file a and five day report with the state us injury of unknown source signs or allegations of abuse, aneither in this case. R-RN 8 HRS 7 DAYS/WK, ed under paragraph (c) or (d) of cilility must use the services of a cor at least 8 consecutive hours bek. ed under paragraph (c) or (d) of cilility must designate a consecutive hours as the director of me basis. In sing may serve as a charge the facility has an average daily or fewer residents. ENT is not met as evidenced serviews and facility failed to ensure the served as Director of Nursing t	F 226		Nurse for at or of oot11. rector of the to met each	4/26/2011

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345204	B. WI			Į.	C 3/2011
	PROVIDER OR SUPPLIER	REHABILITATION		4	REET ADDRESS, CITY, STATE, ZIP CODE 155 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 354	Administrator was a asked about the Di Business Office Macurrently did not hat Assistant Director of the survey team an medication cart and She stated she was and confirmed the DON for several we unaware of a designound of the Corporate Nurse Corporate Nurse Corporate Nurse Corporate Nurse Corporate Nurse Corporate Nurse Corporate Nurse Corporate Nurse Corporate Nurse Spacility. A later Interheld at 2:45 p.m. rethat she had a DON for the minimum 35 Administrator was twas required to woweek in the facility. The staff schedules reviewed and revea specified on the nur on 4/13/11 at 2:50 peen the Interim DO been the Inter	not in the building. When rector of Nursing (DON), the transper stated the facility ve a DON. At 9:15 a.m. the of Nursing (ADON) met with dispersion of ADON at the position of ADON facility had been without a seks. The ADON was east of the facility had been without a seks. The ADON was east of the facility had been se 3/23/11. She stated the rouse of DON until a liked. She reported that the consultants or the ADON was to role of DON until a liked. She reported that the consultant, a Registered Nurse, N. She stated she was ral number of hours the poent acting as the DON in the role with the Administrator vealed she had no verification it assigned to cover the facility hours a week. The unaware the designated DON is for 3/11 and 4/11 were alled no designated DON was	F	354			•

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		(X3) DATE SURV COMPLETE	
		345204	B. WING		04/13/2	2011
	PROVIDER OR SUPPLIER CREEK HEALTH AND	REHABILITATION		REET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE C	(X5) COMPLETION DATE
F 354 F 431 SS=D	employee of the Co the DON in the faci She explained the a spent assisting othe explanation why sh facility for the requi- week. 483.60(b), (d), (e) I LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in accurate reconcilial records are in orde controlled drugs is reconciled. Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartmen controls, and permi have access to the The facility must pro- permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when	priporation and was working as lity for 28 to 32 hours a week. The mainder of her time was er facilities. She offered no e was not working in the red minimum of 35 hours a present and the services of clist who establishes a system at and disposition of all sufficient detail to enable and that an account of all maintained and periodically als used in the facility must be used in the facility must be used in the facility must be used in the facility must be used in the facility must be used in the facility must be used in clude the ory and cautionary expiration date when the state and Federal laws, the lidrugs and biologicals in the sunder proper temperature to only authorized personnel to	F 354	•	e effects. bund to lent oren rviced on ne ro months t at pe reported	4/15/2011

~10 (551)	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. 8U		PLE CONSTRUCTION		E SURVEY PLETED
}		345204	B. WI	1G_		04	C 1/13 <u>/2011</u>
l	PROVIDER OR SUPPLIER CREEK HEALTH AND	REHABILITATION		45	EET ADDRESS, CITY, STATE, ZIP COD 16 VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 431		inimal and a missing dose can	F	131			
	by: Based on observation terviews and facilificatility failed to ensistered at bedside for residents (Resident The findings are: Resident #3 was at 2/28/11 with diagnor debility, chronic resident, chronic resident #3's care (MDS) dated 3/2 had no cognitive imassistance with Act Resident #3's care medications were to by a licensed nurse on 4/13/11 at 10:00 observed sitting on the resident was a medication and the medication and 10:05 a.m. Resident resident's between the billitation servicion the resident's be	dmitted to the facility on bees that included weakness, piratory failure, hypertension of most recent Minimum Dala 17/11 specified the resident inpairment and required limited witles of Dally Living (ADLs), plan dated 3/15/11 specified to be administered as ordered to a.m. the resident was the edge of her bed. Beside purple disk labeled "Advair" (a lent #3 was questioned about reported it was her inhaler. At 11 18 18 19 19 19 19 19 19 19 19 19 19 19 19 19					
	2/28/11 with diagnodebility, chronic resumong others. The Set (MDS) dated 3/had no cognitive imassistance with Act Resident #3's care medications were to by a licensed nurse On 4/13/11 at 10:00 observed sitting on the resident was a medication). Resident medication and 10:05 a.m. Residen rehabilitation service on the resident's behousekeeping staff resident's room and Manager entered Robserved the medication medication and manager entered Robserved the medication and manager entered Robserved the medication medication and manager entered Robserved the medication in the resident's room and Manager entered Robserved the medication in the resident's room and Manager entered Robserved the medication in the resident's room and Manager entered Robserved the medication in the resident's room and Manager entered Robserved the medication in the resident in th	pses that included weakness, piratory failure, hypertension of most recent Minimum Data 17/11 specified the resident upairment and required limited ivitiles of Dally Living (ADLs), plan dated 3/15/11 specified to be administered as ordered to be administered as ordered to a Da.m. the resident was the edge of her bed. Beside purple disk labeled "Advair" (a lent #3 was questioned about reported it was her inhaler. At 1#3 left her room to attend es. The medication remained					

NAME OF PROVIDER OR SUPPLIER STONECREEK HEALTH AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES EEACH DEFICENCY MUST BE PRECEDED BY FULL FAGY PREFIX TAG PROVIDERS PLAN OF CORRECTION EACH CORRECTIVE ACTION IS NOULD BE COMPLETION EACH CORRECTIVE ACTION IS NOULD BE COMPLETION COMPL		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP ILDING	LE CONSTRUCTION	(X3) DATE S COMPLE	
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F 431 Continued From page 11 On 4/13/11 at 10:15 a.m. the Unit Manager was interviewed and stated no residents in the facility were assessed for self-administration of medication. She confirmed the resident should not have had the medication in her room. She reviewed Resident #3's Medication Administration Record (MAR) and confirmed the resident was not to self-administrate medications. The Unit Manager reported the resident would have gotten the medication from the licensed nurse. On 4/13/11 at 10:30 a.m. licensed nurse (LN) #1 was interviewed and reported she left line medication in the resident's room when she administered the resident's room made the medication should not have been left in the resident's room unattended. She explained that while she administering the resident's medications, she was called out of the resident's room and left the Advair medication in the room. She stated this was the first time it had happened and added she had hoped to keep the medication in her room so she			REHABILITATION		45	5 VICTORIA ROAD		
On 4/13/11 at 10:15 a.m. the Unit Manager was interviewed and stated no residents in the facility were assessed for self-administration of medication. She confirmed the resident should not have had the medication in her room. She reviewed Resident #3's Medication Administration Record (MAR) and confirmed the resident was not to self-administer medications. The Unit Manager reported the resident would have gotten the medication from the licensed nurse. On 4/13/11 at 10:30 a.m. licensed nurse (LN) #1 was interviewed and reported she left the medication in the resident's room when she administered the resident's morning medications at 8:00 a.m. LN #1 confirmed the medication should not have been left in the resident's room unaltended. She explained that while she administering the resident's medications, she was called out of the resident's room and left the Advair medication in the room with Resident #3. On 4/13/11 at 2:00 p.m. Resident #3 was interviewed again and reported LN #1 left the medication in her room. She stated this was the first time it had happened and added she had hoped to keep the medication in her room so she	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	(X5) COMPLETION DATE
	F 431	On 4/13/11 at 10:15 interviewed and state were assessed for medication. She come that have had the more reviewed Resident Record (MAR) and not to self-administed Manager reported to the medication from On 4/13/11 at 10:30 was interviewed an medication in the readministered the readministered the readministering the readministering the recalled out of the research and the control of the research	5 a.m. the Unit Manager was sted no residents in the facility self-administration of confirmed the resident should redication in her room. She #3's Medication Administration confirmed the resident was er medications. The Unit he resident would have gotten in the licensed nurse. Dia.m. licensed nurse (LN) #1 of reported she left the esident's room when she esident's morning medications confirmed the medication en left in the resident's room xoplained that while she esident's room and felt the in the room with Resident #3. Dia.m. Resident #3 was and reported LN #1 left the form. She stated this was the pened and added she had medication in her room so she	F	431			