PRINTED: 05/08/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(>	(3) DATE SURVEY COMPLETED
		345204	B. WING _			C 04/14/2025
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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)	OULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00		
F 000	investigation survey withrough 4/09/25. The validated on 04/14/25 changed to 04/14/25. compliance with the remergency Prepared INITIAL COMMENTS	ertification and complaint was conducted on 4/6/25 credible allegation was therefore the exit date was The facility was found in equirement CFR 483.73, ness. Event ID # KYYV11.	FO	00		
	survey was conducted 4/9/25. On 4/14/25 the facility to validate allegations. Therefore to 4/14/25. The follow investigated: NC0021 NC00220618 and NC	d from 4/6/25 through he survey team went back to the facility's credible the exit date was changed ring intakes were 8382, NC00225831, 00220596.				
	1 of the 5 complaint a deficiency.	llegations resulted in				
	(J) CFR 483.65 at tag F8 (J)	was identified at: 84 at a scope and severity 25 at a scope and severity Substandard Quality of				
I	removed on 4/11/25. conducted. Quality of Care	began on 12/26/24 and was An extended survey was	F 6	84		4/15/25
	CFR(s): 483.25 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

05/07/2025

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.

Electronically Signed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	345204	B. WING _			04/1	14/2025
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 0-11	1-4/2020
STONECREEK HEALTH AND REHA	ABILITATION		455 VICTORIA ROAD ASHEVILLE, NC 28801			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT	ION SHOULD BE HE APPROPRIA		(X5) COMPLETION DATE
applies to all treatment facility residents. Base assessment of a reside that residents receive accordance with profes practice, the compreherage plan, and the resident processed or communifollow-up appointment of 2/20/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	re indamental principle that it and care provided to ed on the comprehensive ent, the facility must ensure treatment and care in essional standards of ensive person-centered idents' choices. is not met as evidenced ew, and staff, Medical dic Surgeon interviews, the ete and document gical site. Resident #63 had in 11/28/24 and suffered a dyle region (bony merus bone in the arm) of 63's on 12/13/24 the in open reduction internal all procedure (involves realign the bone and then ether with hardware like is). At Resident #63's it with the Orthopedic Occupational Therapy (OT) OM), pain and edema buildup of fluid) control, in (HEP), and splint wear ine purposes and active indered. This order was not inicated to OT. The 1/23/25 it with the Orthopedic did due to Resident #63 reation Aide rescheduled the 25. The facility did not seek in the Orthopedic Surgeon in elay with the follow-up	F6	Address how corrective ac accomplished for those res have been affected by the opractice: On 11/28/24 Resident #63 unwitnessed fall and was s Emergency Room (ER) who diagnosed with a closed fra olecranon (proximal end of process of ulna. Resident # the facility with a splint in plasurgery (open reduction wit fixation) on 12/13/24. On 12 Resident #63 returned to the office for a follow up and refacility with instructions for Occupational Therapist Resposterior slap splint. Instructions for Application of the posterior slap splint at all the for hygiene purposes and grange of motion purposes. If alled to follow the orthoped recommendations for Residing Implementing removing Resplint for hygiene purposes range of motion. Resident supposed to see the orthoped recommendations.	had an ent to the ere she was acture of right elbow) \$\frac{1}{2}\$ 63 returned lace and had the internal 2/26/24 ne orthopedic eturned to the an ferral, long actions include times except gentle active The facility dic dent #63 by sident #63's and gently #63 was	d to d c e arm ed: t	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>O. 0938-0391 </u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	` ´COM	E SURVEY PLETED
		345204	B. WING				C / 14/2025
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				45	55 VICTORIA ROAD		
STONECR	REEK HEALTH AND REH	ABILITATION		А	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	Continued From page	e 2	F	684			
		of Resident #63's surgical			01/23/25 but was sick and the		
	site from 12/13/24 thr				appointment was rescheduled. On		
		removed the splint on			02/20/25 Resident #63 returned to the	i	
		d a pressure wound over the			orthopedic doctor's office. At the visit		
		closest to the body) of the			splint was removed and a pressure uld		
	1	oow range of motion and			over the medial aspect of the elbow w		
		for the pressure wound. The			some limited range of motion was note		
	Wound Nurse first ob			On 2/20/25 wound nurse received ord	ers		
	was on 2/20/25. The			from wound provider for wound care			
	the Resident weekly I			orders for resident #63. On 02/25/25	the		
	noted the wound was			Wound Provider evaluated the wound			
	device related stage			determined that it was a Stage 3 and 4	1		
	(full-thickness skin ar			pressure ulcer and the orthopedic			
		scia, muscle, tendon,			hardware was exposed. The Wound		
		bone in the ulcer). The			Provider provided wound care orders	and	
	1 -	inued to deteriorate and on			instructed the staff to notify the	otor	
	for emergent surgery	B was brought to the hospital			Orthopedic doctor. The Orthopedic do was notified and placed Resident #63		
		ght elbow with hardware			antibiotic and continue daily wound ca		
	removal. Resident #6				on 02/28/25.	16	
	postoperatively and g				On 03/26/25 Resident #63 required		
	antibiotics for MRSA				surgery to remove the exposed hardw	are	
		us) which were continued			and returned to the facility on 04/01/25		
		n 4/1/25. This deficient			intravenous (IV) antibiotic for Methicilli		
	practice affected 1 of	3 residents reviewed for			resistant staphylococcus aureus (MRS		
	quality of care.				of the wound.		
	, , ,	pegan on 12/26/24 when the			Address how the facility will identify ot	her	
		ment and complete routine			residents having the potential to be		
	I .	dent #63's surgical site.			affected by the same deficient practice) :	
		was removed on 04/11/25					
		emented an acceptable			All residents with new orders and splir		
	credible allegation of				are risk when a physician order is not		
		will remain out of compliance			followed.		
		severity level of D (no actual			On 4/9/25 the Administrator and the	-11	
	-	or more than minimal harm			Director of Clinical Services reviewed		
	that is not immediate				resident orders with outside appointment the past 90 days to appure they we		
		ed and monitoring systems			in the past 90 days to ensure they wer		
	put into place are effe	CUVE.	1		place and correct. No new issues were	5	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345204	B. WING				C 14/2025
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2025
	10 715 21 1 01 1 001 1 2121 1				55 VICTORIA ROAD		
STONECR	EEK HEALTH AND REH	ABILITATION			SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	3	F	684			
	The findings included	:			identified. On 4/9/25 the Wound Nurse completed head-to-toe skin assessment on Residuals.		
	Resident #63 was add	mitted on 11/29/23 with			#63 with no new skin issues noted.	J111	
		ed non-traumatic brain			On 4/9/25 the Director of Nursing (DON	1).	
	dysfunction, hyperten				Assistant Director of Nursing (ADON),		
	disease.				the Wound Nurse completed an audit of	of	
					all current facility residents with all		
		erly Minimum Data Set			pressure and non-pressure wound care)	
	, ,	4 indicated she had severe			and splint orders to ensure the correct		
	cognitive impairment and required maximal assistance with upper body dressing and				physician ordered treatment was in pla All resident treatments and dressings	ce.	
	personal hygiene. Resident #63 did not have any				were correct and matched the physicia	n'e	
		was not receiving any			order.	113	
	therapy.	was not receiving any			On 4/9/25 the Therapy Director comple	ted	
	, ,				an audit of all new admits in the past 3		
	On 11/28/24 at 4:15 F	PM Nurse #1 wrote Resident			days and current facility residents with		
	#63 was found lying of	on her right side, face down			therapy orders to ensure the correct		
	on the floor on the lef				physician ordered treatment was in pla	ce.	
		have right arm in flexed			All resident treatments were correct an	d	
	position and was una				matched the physician's order.		
		ght arm was immediately			On 4/9/25 the Director of Clinical Servi		
	resident was instructe	nt further injury, and the			audited all new admits in the past 30 days and current residents with splints to	ays	
		refully placed onto her bed			ensure the order states to check skin		
	with multiple staff me				integrity before and after applying splin	t	
	Director (MD) was no				All residents had orders.		
		AT (without delay) right			On 4/9/25 Regional Operator, Director	of	
		of the upper arm), elbow,			Clinical Services, the Director of Nursir		
	radius (forearm), and	ulna (one of two long bones			Assistant Director of Nursing, Unit		
	in the forearm) x-ray	due to the fall.			Manager's, Minimum Data Set (MDS)		
					Nurse, and Medical Director conducted	an	
		/28/24 at 4:35 PM the X-Ray			Ad Hoc QAPI (Quality Assurance		
		an x-ray at bedside and			Performance Improvement) meeting to		
		n the epicondyle region of			review and determine root cause of the		
	elbow. The x-ray tech				deficient practice. By root cause analys		
	perform other exams	,			the QAPI committee determined that the		
		dent's condition. A verbal om the on-call provider to			referral form was returned with Resider #63 on 12/26/24 but was not given to the		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	, ,	TE SURVEY MPLETED
		345204	B. WING			C
NAME OF F	ROVIDER OR SUPPLIER	0-1020-1		STREET ADDRESS, CITY, STATE, ZIP CODE		4/14/2025
NAME OF F	ROVIDER OR SUFFLIER				-	
STONECE	REEK HEALTH AND REH	IABILITATION		455 VICTORIA ROAD		
				ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	e 4	F 6	34		
F 004	send to the emergen fracture of right elbow the residents responsorders. The Director contacted, and the [lemedical services (EM facility. Resident #63's emer summary dated 11/2 was brought to the E fractured right olecra forms the tip of the einstructions indicated see an orthopedic sp Nurse #2 progress not 8:46 AM read Reside hospital on a stretchex 2 transfer from the resident is resting coverbal and tactile stir is intact to her right a fingertips noted. Review of a physicial for non-weight bearing worn at all times and (milligrams) every 4 I management were controlled the sevent of a right of resident reported that severity. Resident #63's emergence of the controlled the severity. Resident #63's emergence of the controlled to the con	cy department (ED) for a after the residents fall and sible party was aware of new of Nursing (DON) was ocal county] emergency (IS) was in route to the gency department (ED) (B/24 revealed Resident #63 D after a fall and had a non (bony prominence that (Ibow). The discharge I Resident #63 needed to recialist within 10 days. One written on 11/29/24 at ent #63 returned from the er with maximum assistance stretcher to bed. The mfortably and responds to mulation. The resident's sling rrm with good "CNS" to	F 6	nurse to review. Instead, it was the Medical Record folder to be to the medical record. The recommendations for an Occur Therapist referral and to take the for hygiene and active range of were not implemented. To add root cause the facility implemented education on who will be responsible for ensuring the referral form is betto the facility when a resident foutside appointment so new recommendations or orders call implemented. The Unit Manageresponsible for ensuring the referrance with the resident. If it is weekend or after the Unit Manaleft, the hall nurse will be responsible to the facility when a resident is back from the appowill give her any paperwork at there is no referral form the Unit will call the physician office to copy of the form. Address what measures will be place or systemic changes material ensure that the deficient practice recur: On 4/9/25, the Director of Clinic Services provided education to Administrator, DON and ADON Transportation driver that including the company of the transportation driver that including the company of the transportation driver that including the place or systemic changes material ensure that the deficient practice.	pational the splint off of motion tress the tented consible for cought back thas an the ager has consible. The Manager the intment and that time. If the hit Manager cobtain a the put into de to the will not the N, and ded the Il notify the	

Facility ID: 923521

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						(c
		345204	B. WING _			04/	14/2025
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
				4	55 VICTORIA ROAD		
STONECR	EEK HEALTH AND REF	IABILITATION		Α	SHEVILLE, NC 28801		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	•	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 684	Continued From pag	e 5	F 6	384			
	evaluate her skin and	d found no open wounds or			responsible for obtaining a completed		
		was no threatened skin.			referral form or encounter notes from the	ne	
	There was ecchymos	sis and swelling along the			appointment visit. For appointments/E		
		er elbow and gentle range of			visits occurring on weekends the hall		
	1	er did not seem to cause			nurse will be responsible for obtaining	and	
	significant pain. All o	f the resident's fingers were			reviewing the referral.		
	pink and warm and v	vell-perfused with brisk			B.) Unit manager, or designee, will be		
	capillary refill.				responsible for entering orders and		
	ensuring any therapy referrals are						
		12/6/24 at 11:08 AM written			received by therapy. For		
	_	rsing (DON) indicated			appointments/ER visits occurring on the	е	
	-	onsible party had consented			weekends the hall nurse will be		
		roup for the resident to have			responsible for entering orders and		
		upper extremity (RUE) to			ensuring any therapy referrals are		
	T	12/13/24. Outpatient			received by therapy.		
		heduled with the surgery			C.) The DON will have a list of daily		
	center and pre-opera	ation orders were received.			resident appointments and will follow u		
	T				with the Unit Managers daily to ensure	all	
	The hospital discharg				referral forms have been returned and	:4	
		esident #63 had surgery for			reviewed with any new orders entered	nto	
		nal fixation (hardware placed			the medical record.		
	on bone for stabilizat	follow up with the Orthopedic			D.) Nurse Aides that accompany a resident to an outside appointment are		
		I, take pain medications as			there to care for the resident. The		
	•	nt bearing for operated limb.			Transportation Driver will be responsible	e	
	l	ions were to wear a plastic			for ensuring any paperwork and the		
		e extremity when taking a			referral form are returned to the Unit		
	_	the provider if the splint gets			Manager or hall Nurse.		
	_	ed. Other incision care			E.) On 4/9/25 the Unit Manager was		
	-	not use lotions or creams			educated that when a family member		
		a and call the provider if the			signs the resident out for an outside		
	incision has drainage				appointment they are to follow up with	the	
	The hospital dischar				family when they sign the resident back		
	12/13/24 included ph				into the facility to ensure all paperwork		
		(antibiotic) one (1) tab 100			has been given to the nurse for review.		
	mg twice daily for 14	days to treat or prevent			F.) On 4/10/25 an all call was sent to		
	infections. Also inclu	ided was an order for			facility residents Responsible Party's to	,	
	acetaminophen-hydr	ocodone 325/5 mg oral tablet			notify the Unit Manager or Hall Nurse		
	one (1) every 6 hours	s times 4 days for pain and			when signing the resident out for an		

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		245204	B WING			С
		345204	B. WING _			04/14/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
STONECE	REEK HEALTH AND R	PEHABII ITATION		455 VICTORIA ROAD		
STONEON	CERTICALITI AND IN	KEHABIEHAHON		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From p	200 6	Ге	204		
1 004	1	-	F 6			
	non-weightbearing	g for operated limb.		outside physician appointr return any paperwork/refe		
	There were no ass	sessments of the surgical		appointment to the Unit M	anager or Hall	
	documented by nu	ursing staff from 12/13/24		Nurse.		
	through 12/26/24.			On 4/9/25 DON and ADON	•	
				education to all facility Lice		
		gress note dated 12/26/24		and Nurse Aides that inclu	ided the	
	indicated Resident #63 was seen by the			following:		
		on for a two-week follow-up		A) Unit Manager, or design		
		on internal fixation of a right		responsible for obtaining a		
		e. The resident was fitted with a		referral form or encounter		
	_	arm posterior orthosis (an		appointment visit. For app		
	external device like a brace or a splint) for her			visits on occurring on wee		
		nity by the orthopedic office		nurse will be responsible f	or obtaining and	
		apist. The progress note act the occupational therapy		reviewing the referral.	nnoo will bo	
		ded. The progress note		B.) Unit manager, or desig responsible for entering or		
		for Resident #63 was to be		ensuring any therapy refer		
		wearing the orthosis and with its		received by therapy. For	Tais arc	
		surgical precautions with the		appointments/ER visits oc	curring on the	
		oted that the surgical incision		weekends the hall nurse w	-	
		along the posterior aspect of		responsible for entering or		
		pow. In addition, gentle range of		ensuring any therapy refer		
		w did not cause any significant		received by therapy.		
		stable alignment of her elbow		C.) Nurse Aides that accor	mpany a	
		eduction internal fixation with		resident to an outside app	ointment are	
		he occupational therapist		there to care for the reside		
	educated Residen	it #63 and her caregiver		Transportation Driver will b	be responsible	
	(Transportation Aid	de) on how to wear and provide		for ensuring any paperwor	rk and the	
	care for the orthos	sis (an external medical device		referral form are returned	to the Unit	
	such as a brace o	r splint).		Manager or hall Nurse.		
				D) The DON will have a lis	-	
		n Aide was unavailable for		resident appointments and		
	interview.			with the Unit Managers da		
				referral forms have been r		
		thopedic Surgeon referral order		reviewed, with any new or	ders entered	
		Resident #63 to receive		into the medical record.		
		apy had been scanned into		E.) Any new admissions the		
	Resident #63's he	alth record on 1/2/25 under the		splints or current residents	s with new	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		ONSTRUCTION	(X3) DATE COMF	SURVEY
		345204	B. WING_				C / 14/2025
NAME OF P	ROVIDER OR SUPPLIER	1	-	STR	EET ADDRESS, CITY, STATE, ZIP CODE	04/	14/2025
	10115211 011 001 1 2.2.1				VICTORIA ROAD		
STONECR	EEK HEALTH AND REH	ABILITATION					
				ASI	HEVILLE, NC 28801		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 7	F 6	84			
1 004	tab "medications and orthopedic informatio "consults" tab. The or order was for the resistreat the right olecrar of motion), pain and and HEP (home exer Resident #63 needed times except for hygical AROM (active range times weekly for 8 weekly for 8 weekly for 8 weekly for 8 phones weekly for a phone successful. Resident #63 on 12/2 Nurse #7 for a phones successful. Resident #63's physical 2024 were reviewed on 12/26/24. The DON stated in an PM that Resident #63 appointment schedul on 01/23/25 but Resident pointment was restransportation Aide. Nurse #2 wrote on 1/resident's splint is into "CNS" to fingertips. There were no docum of Resident #63's sur Therapy notes entered 12/26/24 through 2/2	treatments" when all other on was found under the occupational therapy referral ident to be evaluated and to non ORIF with ROM (range edema control, modalities, roise program). It was noted to wear the splint at all ene purposes and gentle of motion) exercises 1 to 2 eeks. ed as the nurse assigned to 26/24. Attempts to contact a interview were not cian's orders for December and found no order entered in interview on 4/7/25 at 3:50 3 had a follow up ed with the Orthopedic MD dent #63 was sick, and the cheduled for 02/20/25 by the 27/25 at 5:41 PM the act to right arm with good mented nursing assessments regical site or Occupational ed in the medical record from 0/25.	F6		splints; the Unit Manager, or designee, be responsible for ensuring residents have orders for splints. If no orders are present, the Unit Manager, or designee will be responsible for obtaining splint orders from the provider. Unit manage designee, will be responsible for enteri orders and ensuring all residents with splints have an order to check skin integrity underneath the splints. DON, designee, will follow up in clinical meetings to ensure the process has be completed. The current facility Licensed Nurses are newly hired nurses not receiving education on 4/9/25 will not be allowed work until the education has been completed. The DON will utilize an act employee list to track completion of education and validate the post education will also be included during orientation for newly hired facility Licer Nurses, to be completed by Director of Nursing or Nurse Manager. Indicate how the facility plans to monitority performance to make sure solutions are sustained: The DON/Designee will complete quality assurance monitoring of outside reside appointments/new admissions to ensurance up on. Monitoring will be completed 5x week during clinical meeting x 8 weeks weeks week	e e e, r, or ng or een d l to live tion l. to live ent e ed per e, ent e ed per e,	
	An Orthopedic Surge	0/25. con progress note dated esident #63 was seen today				5,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	PLE CONSTRUCTION G		E SURVEY IPLETED
	345204	B. WING			C I/14/2025
NAME OF PROVIDER OR SUPPLIER	0.020.		STREET ADDRESS, CITY, STATE, ZIP COD	•	14/2025
NAME OF TROVIDER OR GOTT EIER				_	
STONECREEK HEALTH AND RE	HABILITATION		455 VICTORIA ROAD		
			ASHEVILLE, NC 28801		
PREFIX (EACH DEFICIENT	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684 Continued From pa	ge 8	F 6	84		
for a follow-up of he Orthopedic Surgeor resident on 12/26/2 to come back 4 we and it had been alm saw her. The program had been wearing to nursing aide with he taking it off during to splint, the Orthoped noticed a pressure (area closest to the limited elbow range had steri-strips on he with the Orthopedic concerned him as to whether she had be splint to work with the Surgeon indicated device and ordered elbow wound. Addit elbow wound was found incision and did not there was no concerned her elbow and wan right away if it becard surgeon wanted to appointment on 3/2 Medication Aide #1 1:33 PM. She state to Resident #63 regulation and Februare remembered Residing tarm in Decemand she had never never seen any oth	er right olecranon fracture. The n wrote that he last saw the 14, the resident was supposed eks after that appointment, nost 2 months since he last ess note included the resident he splint at night and the er said the resident had been he day. Upon removing the dic Surgeon indicated he wound over the medial aspect body) of the elbow with er of motion. Resident #63 still her elbow from the last visit surgeon and he wrote that it to the hygiene of this area and een spending time out of the herapy. The Orthopedic he was discontinuing her splint wound care for the medial ar away from her surgical ar away from her surgical ar appear infected. He indicated ern for exposed hardware in ted to be called by the facility me infected. The Orthopedic see the resident for an	F 6	The Director of Nursing will refindings of the monitoring to the Assurance Performance Improcommittee during monthly Quand will make changes to the necessary to maintain compliance is 4/15/25	he Quality rovement API meetings plan as ance.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED
		345204	B. WING		C 04/14/2025
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	04/14/2023
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F 684	that held it in place. a smell and did not recomplaining of pain. Nurse #4 was interval Nurse #4 worked was Resident #63 on nig assigned to the resident has been been been been been been been bee	searm and it had Velcro straps She stated she never noticed recall Resident #63 in her right arm. Viewed on 4/09/25 at 1:50 PM. as usually assigned to the shift and had been dent in December 2024 She stated she had never the resident and had not in her right arm smell. Nurse eck the capillary refill and sident and that the resident fi pain. Nurse #4 stated her the splint was supposed to 3 because she did not see ig it off. The do n 4/9/25 at 1:32 PM and the red Resident #63 having 2 ints and that the resident was a NA #3 stated she was blint was to stay on at all the had never noticed a tents wound and the resident hicate if she was in any pain. It #5 would sometimes If NA #5 would tell her nurse. The wound Nurse wrote with the resident had wrap and cast padding on her of after removing her splint. The oved, the resident was all open area to her right	F 68		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ \ \ \ \ \ \	IPLE CONSTRUCTION		(X3) DATE : COMPL	
		345204	B. WING_			04/) 14/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	1 04/	14/2023
				455 VICTORIA ROAD			
STONECE	REEK HEALTH AND REH	ABILITATION		ASHEVILLE, NC 28801			
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F 684	Continued From page	e 10	F 6	684			
1 004	(centimeters) x 0.9 cr discoloration located was mild serous drair clear to yellow in colo had complained of mi performed that resolv removed. Resident #6 have hypergranulatio healing tissue) above Wound Provider was were received from the Wound Nurse stated it was not time since it was place. Nurse stated it was he resident's surgical site. Orthopedic Surgeon of the wound and he alse for treatment orders. Wound Provider orde with Dakin's solution germs) to pat dry, cover with tape. Was a daily treatment. The Wound Provider' Wound Nurse on 02/2 right elbow wound with and pat dry. Apply xe cover with a non-stick (gauze bandage rolls surgical tape. Change	around wound edges. There hage (wound discharge, or) noted and the resident all pain when palpation was ed once the stimulus was 63 was observed to also in tissue (overgrowth of the ulcer as well. The notified, and new orders he Wound Provider. The wound Provider. The hat Resident #63 came back appointment on 2/20/25 and wearing her splint for the first led on her. The Wound his first observation of the least the wound Provider. The Wound Nurse said the red the wound to be treated (diluted bleach used to kill wer the wound Nurse said it and as needed.					
		had reached out to the Surgeon regarding the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		345204	B. WING			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 455 VICTORIA ROAD ASHEVILLE, NC 28801)4/14/2025 ———————————————————————————————————
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F 684	and to schedule the appointment. The a for Thursday 02/27/ orthopedic office wa Wound Providers or recommendations a regimen that was in wrote he had spoke Orthopedic Surgeor be transcribed to the progress note read attempted to reach get further clarificati was sent to the Orth Resident #63 was fi Provider on 2/25/25 the right elbow wou loss overlying the old the surgical hardway bed base and the whave developed secondicated the wound medical device relatification or directly palpable ligament, cartilage of measuring 0.5 cm x Wound Provider wrowound had full thick right medial epicondend of a long bone) present. The right reported to have destatus post ORIF right extends the surgical full-thickness skin and the surgical device relatification of the surgical full-thickness skin and the surgical device relatification of the surgical full-thickness skin and the surgical full-thickness ski	residents 6-week follow-up ppointment was rescheduled 2025 at 8:00 AM. The as updated regarding the urrent treatment and the current treatment place. The Wound Nurse in to the triage nurse for the who said a message would be Orthopedic Surgeon. The the Wound Nurse had out to the orthopedic office to on and a second message mopedic Surgeon. The Wound Provider noted and had full-thickness tissue decranon. On examination, are was noted in the wound ound site was reported to condary to a brace status post in. The Wound Provider at was consistent with a sted stage 4 pressure injury and tissue loss with exposed fascia, muscle, tendon,	F 68	34		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345204	B. WING				14/2025
	ROVIDER OR SUPPLIER	ABILITATION	1	4	TREET ADDRESS, CITY, STATE, ZIP CODE 55 VICTORIA ROAD SHEVILLE, NC 28801		
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F 684	wounds. The treatmemedial elbow wound Surgeon to cleanse to pat dry and apply xer Then cover it with no with rolled gauze wrat treatment orders for the exposed surgical hard the wound with quart moistened gauze to produce the wound Provider add Orthopedic Surgeon base of right elbow were commendation about the evaluation per the Orthoped Wound Provider add Orthopedic Surgeon base of right elbow were commendation about the evaluation per the Orthoped Wound Provider add Orthopedic Surgeon base of right elbow were commendation about the evaluation per the Orthoped Wound Provider add to cleanse a quarter strength Dakit Loosely pack with a compad, wrap with kerlix surgical tape. Chang soiling or dislodgement A physician order from a 2/26/25 indicated (antibiotic) 100 mg two days for medial elbow A review of the treatment ord initialed completed or 2/26/25.	ent orders for the right were from the Orthopedic he wound with normal saline, roform to the wound bed. n-adherent pad and secure up daily. The wound the right elbow wound with dware were to loosely pack er strength Dakin's provide topical antimicrobial ic Surgeons approval. The ed she requested staff notify of the hardware exposed in round with the treatment eve and requested for further othopedic Surgeon. and Provider wrote an order right elbow wound with in's solution and pat dry. quarter strength Dakin's d cover with a non-adherent Secure with soft cloth e daily and as need for ent. and the Orthopedic Surgeon doxycycline hyclate vice daily by mouth for 21	F	684			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		TE SURVEY
		345204	B. WING _			C)4/14/2025
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 455 VICTORIA ROAD ASHEVILLE, NC 28801	•	J4/14/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 684	A progress note date Orthopedic Surgeon seen for follow-up of olecranon. Resident reduction and interna Orthopedic Surgeon seen him the previous her splint off and get Surgeon noted he disbeen moving much a and her splint was streturned to the clinic Surgeon's request be from Resident #63's the medial elbow wo wound over the post opened up and you obottom of the wound aspect was healing of small wound now presome serosanguined red drainage) coming that he did think he splate in the base of the an order for doxycyclaily for 21 days preforthopedic Surgeon in 3 weeks. He wrotneed to be removed The resident next apscheduled on 3/26/2	ed as completed 02/26/25, 25 on the TAR. ed 02/27/25 from the indicated Resident #63 was her fractured right #63 was treated with open al fixation on 12/13/24. The wrote Resident #63 had us week and was able to take her moving. The Orthopedic d not think Resident #63 had at the skilled nursing facility ill in place. Resident #63 today at the Orthopedic ecause he received a call Wound Nurse who stated und was healing but the erior aspect of the elbow had could see the plate at the . The wound over the medial quite nicely and there was a esent over the olecranon with ous drainage (thin, pinkish, g from that wound. He wrote saw Resident #63's olecranon he wound. The note included line (antibiotic) 100 mg twice scribed on 02/26/25. The wanted her to be seen again e that the hardware might if the wound did not heal up. pointment date was 5 at 10:30 AM.	F 6	84		
	and wrote in the prog wound had decrease	r saw Resident #63 on 3/4/25 gress note the right elbow ed in length and width with an ted measuring 0.3 cm x 0.3				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	I ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345204	B. WING _			C 4/14/2025	
	ROVIDER OR SUPPLIER	ı		STREET ADDRESS, CITY, STATE, ZIP COL 455 VICTORIA ROAD ASHEVILLE, NC 28801		4/14/2025	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	there was a decrease and the exposed surin wound bed base. wound had measure 0.2 cm depth with a covolume. The Wound for the right elbow wo treatment of normal sapply xeroform to the cover it with nonadher olled gauze wrap da antimicrobial control balance. The treatmexposed hardware would with loosely packing quarter-strength Dake to continue with the cotoprovide topical ant progress note include acute infection for an Aphysician's order of posterior biceps wou pat dry. Apply xerofod dressing) to wound be pad. Wrap with kerlissurgical tape. Chang The Wound Provider 3/11/25 indicated right hardware measured depth and was healing noted there was a sli with an increase in gound bed and the easy present in wound	The Wound Provider wrote e in overall wound volume gical hardware was present. The right medial elbow ments of 0.2 cm x 0.2 cm x decrease in overall wound. Provider's treatment orders ound were to continue the saline cleanse to pat dry and e wound bed. Additionally, to erent pad and secure with aily to provide topical and to promote moisture ent orders for the wound with ere to continue treatment the wound with in's moistened gauze. Then current secondary treatment cimicrobial control. The ed there were no signs of any wound. Lated 3/05/25 read clean and with normal saline and rm (non-adhering wound bed and cover with a nonstick of the control with soft cloth.	F 6	84			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION			LETED
		345204	B. WING _		_		C 14/2025
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BI ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 684	the right elbow wounduarter-strength Dak loosely packing the work Dakin's moistened gasilicone bordered supto provide topical anto A Wound Provider or cleanse right elbow work Dakin's solution and quarter strength Dakin with a silicone border and change daily as The Wound Provider 3/18/25 revealed the surgical hardware ex 0.2 cm x 0.4 cm deptimproved. The Wound the wound had signs edema and mild sero	wound treatment order for d was changed to a in's irrigation, followed by wound with quarter strength auze. Then to secure with per absorbent dressing daily imicrobial control. der dated 3/11/25 read wound with quarter strength pat dry and loosely pack with in's moistened gauze. Cover red super absorbent dressing	F	684	EFICIENCY)		
	erythema, no odor, a Resident #63 did not wound treatment ord quarter-strength Dak loosely packing the w strip then secure the super absorbent dres antimicrobial control. A Wound Provider or irrigate the right elbor strength Dankins. Pa with moistened quart Cover with a large ga	ere was no induration, no nd no calor (warmth). have a fever on exam. The ers were changed to in's irrigation, followed by yound with lodoform packing area with silicone bordered exing daily to provide topical der dated 3/18/25 read to w wound with quarter at dry/ loosely pack wound er strength Dakin's gauze. auze wound dressing and uze and tape once daily and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345204	B. WING _			C 04/14/2025
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F 684	the Wound Nurse recharacteristics were seropurulent drainag. The Wound Care Pr Director were notifie for change in treatm 500 mg twice a day obtain a Complete Edifferential, Sedimer /C-Reactive Protein TAR and MAR were carried out as indicated attempted to reach I current plan of care leave message. The Physician's orderight elbow wound we Pat dry/loosely pack quarter strength Dallarge gauze wound rolled gauze and tag. Physician's order da Ciprofloxacin (antibit 10 days prophylaxis	en on 3/23/25 at 10:43 AM by ad, new wound observed with moderate ge (cloudy drainage) noted. ovider and attending Medical d. New orders were received ent, Ciprofloxacin (antibiotic) for 10 days prophylaxis, and Blood Count (CBC) with nation Rate (Sed Rate), (CRP) on 03/24/2025. The updated, and orders were ted. The Wound Nurse RP regarding new orders and and was unable to reach or er dated 3/23/25 read irrigate with quarter strength Dakin's, a wound with moistened kin's gauze. Cover with a dressing and secure with the once daily and as needed.	F	584		
	on 03/24/2025. The Wound Nurse we that the orthopedic or regarding the change and increased inflance seropurulent drainage signs were 98.3, 85	vrote on 3/24/25 at 1:25 PM office was contacted e in wound characteristics mation present with ge noted. The resident's vital pulse, 20 respirations, 124/85 to oxygen saturation on room				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345204	B. WING _		_	C 4/14/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	<u> </u>	4/14/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 684	Continued From pag	e 17	F6	84			
I 00 4	air with no shortness #63 had lab work obt on by mouth antibioti infection. A physician's order dright elbow wound wisolution, pat dry/ loos moistened quarter st with a large gauze with rolled gauze and needed. The Wound Provider 3/25/25 and wrote in right elbow wound wiexposed measured 0 depth and the wound Wound Provider wrot of edema, induration soft tissue) and mode was present in the el indicated there was a seropurulent drainag infection) present on The resident was in right palpation of the wour medication was required nursing staff. The Wight premedicate the resident exam. The would care exam. The would have been sorbent dressing a continued with cover absorbent dressing as	of breath present. Resident rained today and continues or for prophylaxis wound ated 3/25/25 read to irrigate th quarter strength Dakin's sely pack wound with rength Dakin's gauze. Cover ound dressing and secure of tape twice daily and as saw Resident #63 on the progress note that the strength surgical hardware 1.9 cm x 0.9 cm x 0.8 cm 1.1 had not improved. The set there was a large amount (thickening and hardening of the erythema (redness) bow. The Wound Provider a large amount of the (indicates potential exam with no odor noted. The moderate pain with the moderate pain with the moderate pain with the moderate pain with the moderate pain prior to wound and care treatment order was trength Dakin's irrigation and with quarter-strength acking strip. The order ing the area with rolled gauze wo times daily) to provide		84			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	DING (X		X3) DATE SURVEY COMPLETED	
		345204	B. WING _			C 04/14/2025	
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F 684	elbow wound to irrigate Dakin's, pat dry. Loo moistened quarter structure with and large gauze with rolled gauze and needed. The Orthopedic Surg 3/26/25 and signed at #63 returned to the condiced over the past redness, swelling and wound. The Orthopedic Surgand wound. The Orthopedic Surgand wound if the orthopedic Surgand wrote he did not osteomyelitis (infectional words and wrote he did not osteomyelitis (infectional words) between the would admitted to the hospi antibiotics and postol better provide treatm forward. A nurse's note writter Nurse #3 indicated Refere appointment at the scheduled surgery for the order of the words.	dated 3/25/25 read for right atte with quarter strength asely pack wound with rength Dakin's gauze. Cover wound dressing and secure I tape two times daily and as eon's progress note dated at 11:51 AM wrote Resident linic today. The facility had few days increasing draining from her elbow adic Surgeon wrote the ed an infection going down to elecranon bursa (small tip of the elbow). The ed an x-ray was conducted surgeon reviewed the x-ray see any indication of the bone) from the ence. The Orthopedic should proceed to the for irrigation, debridement aged or infected tissue) and the Orthopedic Surgeon allow the resident to be tall for IV (intravenous) peratively and for him to eent to the resident moving	F6	84			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801			1 04/14/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	dated 04/1/25 reveal to the hospital on 03 debridement of her removal. A progres admitting hospitalist received from the ori and erythematous (refor emergent surgery was admitted postop antibiotics for MRSA Staphylococcus aure summary dated 04/0 to receive PT or OT resident will receive (peripherally inserted thin tube that's insertarm and passed through the programment. The diorders to assist with 12 hours for wound a after 5/5/25. Addition getting labs drawn er trough, CRP, ESR, Ethe resident is to be operative arm and to Orthopedic Surgeon. A nurse's note dated #2 indicated Resider facility on 04/01/25 as sent to the hospital corthopedic office due The resident was tak for irrigation and debuith hardware remove	ed Resident #63 was brought /26/25 for irrigation and ight elbow with hardware is note dated 3/27/25 by the wrote Resident #63 was chopedic office with a swollen ed and swollen) right elbow of on 3/26/25. Resident #63 was chopedic office with a swollen ed and swollen) right elbow of on 3/26/25. Resident #63 was deratively and given IV (Methicillin-Resistant eas). The hospital discharge 1/25 read Resident #63 was 2 to 4 days week. The IV antibiotics via PICC discentral catheter, is a long, and through a vein in your easily to the larger veins near und dressings were to remain edic Surgeons follow up scharge summary included IV vancomycin 1 gram every and bone infection and end and orders read to assist with every Monday for vancomycin BMP, and CBC. Furthermore, non-weight bearing to 1 follow-up with the 1 follow-up wi	F 68	34			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	1	04/14/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CORRECTION SHOUTH CORRECTIO	OULD BE	(X5) COMPLETION DATE
F 684	wet a call was to be Surgeon immediately port (Intravenous car arm) placed in her riv vancomycin (antibiot until 05/8/25. A physician order wr #63 indicated vancor gram/200 milliliters in methicillin-resistant \$3 (MRSA). Infuse over per hour PICC to right 05/08/25. Order written on 04/0 extremity to remain in appointment on 4/16 circulation to right upon A review of the April for assessing circulate every shift was signed. Review of the medic #63 was not seen by 12/26/24 order from 04/02/25. The Therapy Director 04/08/25 at 4:58 PM receive a referral for evaluated or receive stated the splint on F was not difficult to rethe elbow and arm shall the splint devices a referral devices a referral for the elbow and arm shall the splint devices a referral for the elbow and arm shall the splint devices a referral for the elbow and arm shall the splint devices a referral for the elbow and arm shall the splint devices a referral for the elbow and arm shall the splint devices a referral for the elbow and arm shall the splint devices a referral for the elbow and arm shall the splint devices a referral for the elbow and arm shall the splint devices and the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the splint devices are for the elbow and arm shall the elbow are for the elbow and arm shall the elbow	dry until follow-up, if splint got made to the Orthopedic y. Resident #63 had a midline theter inserted into the upper ght upper chest and received ic) 1 gram every 12 hours ditten on 04/01/25 for Resident mycin-diluent combo 1 htravenous for right elbow Staphylococcus aureus one hour with 200 milliliters into chest, every 12 hours until 201/25 for splint to right upper in place until follow-up in place until follow-	F6	884		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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		345204	B. WING			1	14/2025
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
STONECE	REEK HEALTH AND RI	EHABILITATION			VICTORIA ROAD		
				AS	HEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	provider. The The seen a therapy refe occupational theral evaluate the reside indicated on the recare for therapy we treatment, and the splint would have border. The Therapy Resident #63's splint and checking infection. She said be used to clean the Therapy Director scremoved the reside flow would be evaluated she felt Resand blood flow mig of a pressure wour it was a collaboration rursing to ensure the care needed for the progression. The say she received the providers in differentes or direct refebeen given to her bus Director stated she have been seen by range of motion and A follow-up interview occurred on 04/08/Resident #63 was September 2024 a until 04/02/25. The	agreement from the orthopedic brapy Director said had she erral for Resident #63, an pist would have been sent to ent specifically for the need ferral. Resident #63's plan of build then be developed for her resident's hygiene under the been done per the treatment or Director said hygiene for not would include removing the graph and a washcloth would be skin. Additionally, the said when the splint was ent's range of motion and blood unated. The Therapy Director ident #63's range of motion had have helped reduce the risk and from developing. She stated on between therapy and the resident was receiving the eresident's therapy Therapy Director went on to herapy referrals from outside not ways such as progress real orders that would have by nursing. The Therapy endid think Resident #63 should of the therapist in the facility for	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345204	B. WING _			C 04/14/2025
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIF 455 VICTORIA ROAD ASHEVILLE, NC 28801	CODE	0-11-12-02-0
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	-	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 684	Continued From page help with range of mr #63 had a diagnosis have been able to do The DON verified in 3:50 PM that Reside orthopedic appointment the splint was removed from 12/26 thought the resident the splint removed from 12/26 thought the resident the splint removed from 10 NoN indicated she sprogress note but has She explained these and they were scannedical record on distated she thought the facility's OT. The DON stated in a 1:57 PM that she was office referral order of #63 to receive occuper week for hygiene.	ge 22 notion. She stated Resident of dementia and would not o a HEP without assistance. an interview on 04/07/25 at ant #63 went to a follow-up nent on 02/20/25 and when yed by the Orthopedic or pressure wound under the ded the splint had not been ye4 to 2/20/25 because she was not supposed to have or any reason as reported to ation aide on 12/26/25. The saw the 12/26/24 orthopedic and not seen the referral order. were separate documents and into the electronic different tabs. The DON the orthopedic DT and not an interview on 04/09/25 at as not aware of the orthopedic dated 12/26/24 for Resident obtainal therapy 1 to 2 times and active range of motion.				
	order during the interpretation order from the Orthor been read and revieworking on 12/26/25 resident returned from order should have bechart in with other or DON said normally, provider was handed	nade aware of the referral rview. The DON stated the spedic Surgeon should have wed by the nurse who was (Nurse #7) when the symmetry means the proposition of the symmetry of				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345204	B. WING		04/	; 14/2025
	ROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		4/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	medical records beforecords would scan in notes and then give the nurse. The DON thougiven to medical recordelivered to her or the Resident #63 returned Transportation Aide recordelivered to her or the Resident #63 returned to remove the splint. The Orthopedic Surgeon of the Orthopedic Surgeon of the Orthopedic appointment. The Orthopedic appointment of 04/09/25 at Resident #63 was his office with a fractured and had surgery to stand had surgery	ent information was given to be the DON. Medical on the appointment progress the hard copy to the DON or taght the referral order was rds, scanned in and not be residents nurse when do 12/26/25. The response on 12/26/25 that the resident was not the DON said orders are morning meeting, and did from Resident #63's rent on 12/26/24. Been was interviewed via 3:30 PM. He stated of patient and had come to his right olecranon on 12/05/24 abilize the fracture on redic Surgeon stated he saw 6/24 for a follow-up red in his notes he ordered to be removed for hygiene resident's facility. The resident's facility in the resident's facility. The resident's facility in the resident for 2 relibow could become very not #63 had a diagnosis of diassistance with the splint	F 68	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345204	B. WING _			C 4/14/2025	
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CC	•	+/ 1+/2023	
STONECR	REEK HEALTH AND F	REHABILITATION		ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	times per week ar Resident #63's far Aide. He said he is Transportation Aid appointments and Resident #63 nee stated he reviewe Transportation Aid appointment with said Resident #63 and should have if therapy as he ord went on to say the Resident #63's ell directly to the split 12/26/24 until 2/26 susceptible to device comorbidities Resident #63's ell directly to the split 12/26/24 until 2/26 susceptible to device advanced age. The not removing the did increase the ripressure wounds The splint could hor therapy to check the splint could have a consultation for all for Resident #63 in December 2024, say the Orthopedia.	orbition and hygiene for 1 to 2 and the orders were sent to cility with the Transportation recalled the resident having a de with Resident #63 at the de he told her about the care ded along with his orders. He ded his orders with the de before Resident #63 left her him. The Orthopedic Surgeon de was in a skilled nursing facility deen receiving occupational dered. The Orthopedic Surgeon de 2 wounds that developed on dow could not be attributed and that was not removed from do 2/25. The elbow was deloping wounds with the dident #63 had and her de Orthopedic Surgeon stated desplint for hygiene and therapy sk for the resident to develop under the splint and infection. ave been removed by nursing	Fé	84			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		ATE SURVEY DMPLETED
		345204	B. WING _			C 04/14/2025
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		04/14/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	orthopedic orders to The Administrator wa 2:03 PM and stated referral orders from reviewed and the ore the resident to receive have been captured. The facility's Administration of immediate Jeopardy. The facility provided allegation of immediate Jeopardy. The facility those reside likely to suffer, a ser result of the noncommodiate of the noncommodiate of the series of ulna. Resident with a splint in (open reduction with 12/13/24. On 12/26/26 the orthopedic office to the facility with ins Therapist Referral, le Instructions included times except for hyg active range of motion failed to follow the or for Resident #63 by Resident #63's splin	al Director stated he expected be followed by the facility. as interviewed on 4/9/25 at the Orthopedic Surgeon 12/26/24 should have been ders followed. The order for we OT and hygiene should of on 04/09/25 at 5:15 PM. the following credible ate jeopardy removal: Ints who have suffered, or ious adverse outcome as a spliance: Int #63 had an unwitnessed the Emergency Room (ER) mosed with a closed fracture roximal end of elbow) sident # 63 returned to the in place and had surgery	F	684		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		STRUCTION	(X3) DATE COMP	SURVEY LETED
		345204	B. WING _				C 14/2025
	ROVIDER OR SUPPLIER	ABILITATION		455 VIC	T ADDRESS, CITY, STATE, ZIP CODE CTORIA ROAD VILLE, NC 28801	<u>, </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 684	rescheduled. On 02/2 to the orthopedic door splint was removed a medial aspect of the range of motion was nurse received order wound care orders for the Wound Provider of determined that it was ulcer and the orthoped The Wound Provider and instructed the stadoctor. The Orthoped placed Resident #63 daily wound care on On 03/26/25 Resider remove the exposed the facility on 04/01/2 antibiotic for Methicill aureus (MRSA) of the Because all residents are at risk when a ph followed the following On 4/9/25 the Adminic Clinical Services revioutside appointments ensure they were in pissues were identified.	a and the appointment was 20/25 Resident #63 returned tor's office. At the visit the and a pressure ulcer over the elbow with some limited noted. On 2/20/25 wound is from wound provider for a resident #63. On 02/25/25 evaluated the wound and is a Stage 3 and 4 pressure edic hardware was exposed. Provided wound care orders aff to notify the Orthopedic dic doctor was notified and on antibiotic and continue 02/28/25. It #63 required surgery to the hardware and returned to 25 on intravenous (IV) in resistant staphylococcus in resistant staphylococcus in wound. It is with new orders and splints a with new orders and splints and the Director of the wed all resident orders with it in the past 90 days to place and correct. No new it. I Nurse completed a resident #63	F	684	DEPICIENCY)		
		Nursing (ADON), and the eted an audit of all current					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		345204	B. WING _				C 14/2025
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, 455 VICTORIA ROA ASHEVILLE, NC		1 04/	14/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	Continued From page non-pressure wound ensure the correct phywas in place. All resid dressings were correphysician's order. On 4/9/25 the Therapaudit of all new admit current facility reside ensure the correct phywas in place. All resid and matched the phyyon on 4/9/25 the Director audited all new admit current residents with states to check skin i applying splint. All residence of the process or system facility adverse outcome from when the action will be on 4/9/25 Regional Con 4	care and splint orders to sysician ordered treatment dent treatments and ct and matched the sy Director completed an sin the past 30 days and and the sysician ordered treatment dent treatments were correct sician's order. For of Clinical Services in the past 30 days and a splints to ensure the order integrity before and after sidents had orders. For entity will take to alter the clure to prevent a serious in occurring or recurring, and the complete.	F				
	Director of Nursing, UData Set (MDS) Nursiconducted an Ad Hood Performance Improve and determine root capractice. By root cause committee determine returned with Reside not given to the nurse placed in the Medical uploaded to the medical recommendations for	se analysis, the QAPI d that the referral form was nt #63 on 12/26/24 but was e to review. Instead, it was Record folder to be					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		04/14/2020	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	address the root cau education on who w the referral form is be when a resident has new recommendation implemented. The Uresponsible for ensure with the resident. If it Unit Manager has le responsible. The transponsible. The transponsible in the resident appointment and will that time. If there is Manager will call the copy of the form. On 4/9/25, the Direct provided education of ADON, and Transponsible for the following: A) The transportation Manager or hall nurse from the outside appointment visit. For occurring on weeken responsible for obtain referral. B.) Unit manager, or for entering orders a referrals are received appointments/ER visit weekends the hall not resident in the surface of the surf	on were not implemented. To use the facility implemented ill be responsible for ensuring rought back to the facility an outside appointment so ons or orders can be unit Manager will be uring the referral form returns to it is the weekend or after the fit, the hall nurse will be unsporter will notify the Unit in it is back from the ligive her any paperwork at no referral form the Unit is physician office to obtain a stor of Clinical Services to the Administrator, DON and ortation driver that included an driver will notify the Unit is the resident has returned cointment, the Unit Manager for obtaining a completed bounter notes from the or appointments/ER visits and the hall nurse will be ining and reviewing the responsible and ensuring any therapy distribution of the urse will be responsible for ensuring any therapy	F 68				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345204	B. WING _			C 04/14/2025
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	•	04/14/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From pag	ge 29	F 6	84		
	appointments and w Managers daily to et been returned and rentered into the med D.) Nurse Aides that	accompany a resident to an				
	resident. The Transpressions ible for ensured	are there to care for the portation Driver will be uring any paperwork and the urned to the Unit Manager or				
	that when a family m for an outside appoi with the family when	nit Manager was educated nember signs the resident out nument they are to follow up they sign the resident back sure all paperwork has been or review.				
	residents Responsib Manager or Hall Nur out for an outside ph return any paperwor	I call was sent to facility ble Party's to notify the Unit rse when signing the resident hysician appointment and to k/referrals from the Unit Manager or Hall Nurse.				
	current residents with Manager, or designed ensuring residents horders are present, designee, will be resorders from the providesignee, will be resorder to check skin is splints. DON, or designet.	ions that admit with splints or the new splints; the Unit see, will be responsible for ave orders for splints. If no the Unit Manager, or sponsible for obtaining splint rider. Unit manager, or sponsible for entering orders dents with splints have an integrity underneath the signee, will follow up in the sponsible for entering orders the process has been				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345204	B. WING		04/14/2025		
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	,		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION		
F 684	all facility Licensed included the followin A) Unit Manager, or for obtaining a compencounter note from appointments/ER viweekends hall nursiobtaining and review B.) Unit manager, or for entering orders areferrals are receive appointments/ER viweekends the hall rentering orders and referrals are receive C.) Nurse Aides that outside appointment resident. The Trans responsible for ensureferral form are rethall Nurse. D) The DON will hat appointments and vivial Managers daily to element returned and rentered into the me E.) Any new admissioner of design was a compensation.	I ADON provided education to Nurses and Nurse Aides that ag: designee, will be responsible bleted referral form or a the appointment visit. For sits on occurring on e will be responsible for wing the referral. If designee, will be responsible and ensuring any therapy ed by therapy. For sits occurring on the aurse will be responsible for ensuring any therapy ed by therapy. It accompany a resident to an trace there to care for the portation Driver will be auring any paperwork and the aurned to the Unit Manager or over a list of daily resident will follow up with the Unit nsure all referral forms have reviewed, with any new orders	F 684				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345204	B. WING			l '	0
NAME OF D	ROVIDER OR SUPPLIER	343204	B. WING	97	TREET ADDRESS, CITY, STATE, ZIP CODE	04/	14/2025
	REEK HEALTH AND REH	ABILITATION		45	55 VICTORIA ROAD SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	and ensuring all residorder to check skin in splints. DON, or desiclinical meetings to excompleted. The current facility Lichired nurses not recewill not be allowed to been completed. The employee list to track and validate the post completed and passe communicated to the on 4/9/25. Education orientation for newly Nurses, to be completed and passe communicated to the on 4/9/25, the Analyse Manager. Effective 4/9/25, the Analyse Manager. Effective 4/9/25, the Analyse Manager. Alleged Date of IJ Reconsite validation of this removal for this alleged and passe of the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Second of Clinical Secons and passed of the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director, DOM Worker, Therapy Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director of Clinical Secons and passed on the deficient held on 4/9/25 and in Medical Director of Clinical Seco	der. Unit manager, or consible for entering orders lents with splints have an tegrity underneath the gnee, will follow up in insure the process has been censed Nurses and newly iving education on 4/9/25 work until the education has DON will utilize an active completion of education education written test was ind. This responsibility was DON by the Administrator will also be included during inited facility Licensed ted by Director of Nursing or Administrator and Director of insible for ensuring is immediate jeopardy ed noncompliance.	F	684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		SURVEY PLETED
			D 14//10			С
		345204	B. WING _		04	/14/2025
	ROVIDER OR SUPPLIER EEK HEALTH AND REH	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		
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F 684	therapy to ensure the treatment was in place ST). Splint and press care audits were come orders were included orders. Education was indicated in the remove Clinical Services to the Transportation Driver education note in the conducted on 4/9/25 nurses and nursing a as complete by review sheet and staff intervisincluded a test that earned passed, and each completion and under Furthermore, the educadded to orientation for the staff in the staff intervisions and staff intervisions.	st 90 days and the orders for correct physician ordered to for all disciplines (PT, OT, ure or non-pressure wound upleted and all provider's in the resident treatment as conducted on 4/9/25 as wal plan by the Director of the Administrator, DON, and ADON. An additional removal plan was that included all licensed tides. Education was verified wing the education signature tiews. The education ach participant had signed restanding of the education. cation was verified to be	F	584		
F 686 SS=D	S483.25(b) (1) Skin Integ §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility m (i) A resident receives professional standard pressure ulcers and of ulcers unless the indi demonstrates that the (ii) A resident with pressure with press	rity re ulcers. chensive assessment of a nust ensure that- s care, consistent with ls of practice, to prevent does not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent	F	586		4/17/25

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345204	B. WING		C 04/14/2025
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/14/2025
				455 VICTORIA ROAD	
STONECR	EEK HEALTH AND REH	ABILITATION		ASHEVILLE, NC 28801	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD		BE COMPLETION
F 686	6 Continued From page 33		F 686	6	
		ent infection and prevent			
	new ulcers from deve				
		is not met as evidenced			
	by:			F000	
		ns, record reviews, staff		F686	
		d Care Consultant Nurse		Address how corrective action will be	.d to
	obtain orders, and to	rviews, the facility failed to		accomplished for those residents four have been affected by the deficient	ld 10
		d-spine pressure ulcer		practice:	
	wounds for 1 of 3 resi			practice.	
	reviewed for pressure	,		The facility failed to document two wo	unds
	Toviowed for product diodro.			located on upper spine of resident #6	
	Finding included:			upon admission to facility on 03/15/25	
	J			The facility failed to obtain treatment	
	Resident #61 was add	mitted to the facility on		orders from MD for the two wounds or	۱
		es which included aftercare		upper spine for resident # 61 on 03/15	5/25.
	following joint replace	- ·		The wound nurse identified two wound	
	unspecified dementia			located on upper spine on 03/17/25 w	
				conducting 2nd skin check. Wound nu	
		vation Detail report dated		obtained MD orders on 03/17/25 but fa	
		y Nurse #1 revealed skin		to transcribe the orders to begin on da	
		nperature warm, and skin		of identification, resulting in treatment	
		ons in skin were noted as a the location as left shoulder		being initiated on 03/18/25. Facility failed to provide wound care for	\r
	_	skin alterations were noted.		resident #61 for two wounds located of	
	Would vac. 140 other	Skiii diterations were noted.		upper spine on the following dates	"'
	An interview on 4/07/2	25 at 3:18 PM with Nurse #1		03/15/25, 03/16/25 and 03/18/25.	
		npleted Resident #61's		Address how the facility will identify of	her
		on Detail report and her		residents having the potential to be	
		sment. She stated she left		affected by the same deficient practice	e:
	out the two mid upper	spine wounds in error. She			
		nd a dressing on her spine		Current facility residents have the	
		ne facility, but she had not		potential to be affected by this deficier	nt
		lso stated she was new to		practice.	
	-	t know if there were wound		On 04/16/25 the Director of Nursing	
		Nurse #1 stated she had		completed audit of the last 30 days of	
	· · · · · · · · · · · · · · · · · · ·	lressing with the same		admissions. Audit included documenta	
		ted she did not remember . She also stated that she		accuracy with focus on impairments o skin integrity upon admission, MD	Г
	providing would care	. טווב מושט שנמנבט נוומנ שווב		ann integrity upon aumission, MD	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
							С
		345204	B. WING _			04	/14/2025
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STONECE	DEEK HEVI TH VND DEI	JARU ITATION		45	55 VICTORIA ROAD		
STONECK	REEK HEALTH AND REI	HABILITATION		Α	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From pag	je 34	F 6	686			
F 686	had not notified anyour order on 3/15/25 or 3 had no specific reason anyone to obtain a way resident #61's care 3/15/25 revealed a for skin breakdown remobility and muscle included: assist resident propositing as needed while sitting up in chapper back and were both present of included: consult wo assess the pressure size, presence/abse epithelization weekly. The Weekly Skin Chapper Skin Chap	plan with start date of ocus that resident with turning and d and encourage weight shift air. Resident #61's care plan 8/25 revealed another focus oressure ulcer/injury to her mid upper lateral back which a admission. Approaches und provider as needed and ulcer for location, stage, nce of granulation tissue and	F	386	treatment orders current and in place accurately on day of identification. No variances found. On 04/15/25 Ad Hoc QAPI held to deficient practice and initiate a plan of correction with auditing tools. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will n recur: On 04/16/25 the Director of Nursing provided education for all licensed nurson accuracy of new admission skin assessments, to include documentatio accuracy and obtaining MD treatment orders day of No employee was allowed to work untieducation provided. Education added to General Orientation for all licensed nurson wound nurse. On 04/16/25 the Director of Nursing provided education to the Wound Carenurse on accuracy of order entry for wound treatment orders obtained from MD. Orders are to be obtained	ot ses n	
	The Wound Provide				transcribed day of to ensure no delay i wound care treatment and/or	n	
		dated 3/18/25 revealed 2 d areas: back mid and back k mid pressure area			documentation.		
	measured 0.8 centin cm width with a 0.3 c back mid lateral pres	neters (cm) length and 1.2 cm estimated depth. The ssure area measured 1.3 cm idth and 0.3 cm estimated			Indicate how the facility plans to monitoritis performance to make sure that solutions are sustained. The Director of Nursing/designee will complete quality assurance monitoring new admissions focusing on new		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
		345204	B. WING_			1	C / 14/2025
NAME OF P	ROVIDER OR SUPPLIER	0.020.	<u> </u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE	04	/14/2025
TVAIVIL OF T	TO VIDER OR GOLT EIER				, , ,		
STONECR	EEK HEALTH AND REH	ABILITATION			5 VICTORIA ROAD		
				AS	SHEVILLE, NC 28801		
(X4) ID PREFIX TAG			ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	e 35	F 6	886			
F 686	An order dated 3/18/2 wound and mid latera normal saline, pat dry dressing to wound be dressing daily and as Review of Resident # Records for March ar daily wound care dresigned as completed Resident #61's most (MDS) dated 3/21/25 cognitively impaired a maximum staff assist daily living. The MDS unstageable deep tiss that were present on A wound care observe with the Wound Care #61 had 1 small mid wound had a small air pink around the edge An interview on 4/09/Wound Care Nurse or Resident #61's mid s initiated wound care ocare. He stated there skin loss on the initial he initiated wound care sident to the Wound Practitioner (NP). The	25 read in part for mid spine al spine wound, cleanse with y. Apply a petroleum ed and cover with a border in needed. 261 Treatment Administration and April 2025 revealed the ssing changes had been on 3/18/25 through 4/08/25. 27 recent Minimum Data Set indicated she was severely and required moderate to ance for most activities of 5 further indicated she had 2 sue injury pressure ulcers admission. 27 ation on 4/07/25 at 2:24 PM Nurse revealed Resident spine pressure wound. The mount of clear drainage, was se with a yellow center. 27 at 9:14 AM with the evealed he initially observed pine wound on 3/17/25, orders, and provided wound was some full thickness I observation which is why are orders and referred the d Consultant Nurse e Wound Care Nurse stated	F 6	86	admission skin observation to identify impairments in skin integrity to ensure areas identified have appropriate wour treatment-initiated day of identification. Monitoring to also include any areas identified during second skin check have wound treatment initiated day of admission and/or identification. All new admissions will be audited 5x pweek x 4 weeks, then 5 admissions peweek x 6 weeks, then 5 admissions monthly x 3 months. The Director of Nursing will report on the findings of the monitoring to the Quality Assurance Performance Improvement Committee during monthly QAPI meetiand will make changes to the plan as necessary to maintain compliance. Date of Compliance: 04/17/2025	ve per r	
	changes on 3/17/25 by physician's orders lat	e spine wound care dressing out due to entering the e, they did not trigger on the ation Record and he had not oleted that day.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY PLETED
		345204	B. WING _			C // 14/2025
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		14,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 686	Wound Consultant Nurevealed she had first	25 at 11:25 AM with the	F 6	86		
	spine wounds were confelt the resident had so from no treatment on NP stated that Reside	urrently improving, and she ustained no adverse effects 3/15/25 until 3/17/25. The ent #61's back mid lateral been resolved as of 4/01/25				
	part that the back mid	report dated 4/08/25 read in I spine pressure wound gth and 0.9 cm width with a				
F 761 SS=D	of Nursing and the Adassessments should I resident admission. T notified and treatment admission pressure wastated Nurse #1 was		F 7	61		4/17/25
	Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable.	y and cautionary expiration date when				
	9463.45(n) Storage 0	f Drugs and Biologicals				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345204	B. WING _				C 1 4/2025
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0-11	1-1/2020
STONECR	REEK HEALTH AND REH	ABILITATION		455 VICTORIA ROAD ASHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 761	Continued From page	∍ 37	F7	761			
	Federal laws, the faci biologicals in locked of temperature controls, personnel to have accessed by the State of the Comprehensive E Control Act of 1976 a abuse, except when the package drug distribution quantity stored is min be readily detected. This REQUIREMENT by:	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the simal and a missing dose can			F761 Address how corrective action will be		
	medications when Nu Nurse #4 left medicat	urse #2, Nurse #3, and tions at the bedside for 2 of with medications at the			accomplished for those residents found have been affected by the deficient practice:	d to	
	Findings included: 1. Resident #78 was 12/4/24.	admitted to the facility on			The facility failed to ensure 3 out of 3 residents took their prescribed medical as per medication administration policy 04/06/25. Medications were left at beds for 3 out of 3 residents whom were alerand oriented and did not have a	on side	
	The quarterly Minimu assessment dated 12 #78 was cognitively in	2/30/24 revealed Resident			medication self-administration plan of care.		
		sessment for medication ocumented in Resident cal record.			Residents interviewed on 04/06/25 and denied the request to self- administer t prescribed medications.	heir	
	On 4/6/25 at 9:56 AM	l an observation and			Medications were removed from bedsic for 3 out of 3 residents on 04/06/25.	et	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	DOVIDED OD SUDDUED	343204	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	1/14/2025
NAME OF PI	ROVIDER OR SUPPLIER				, , ,		
STONECR	EEK HEALTH AND REI	HABILITATION			I55 VICTORIA ROAD		
		-		,	ASHEVILLE, NC 28801		
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F 761	Continued From pag	ne 38	F 7	761			
	interview were comp	leted of Resident #78 and his					
		was observed lying in his bed			On 04/06/25 Medical Director notified b)V	
		e positioned next to his bed.			the Director of Nursing.	.,	
		as observed sitting on his			and I moster or reasoning.		
		ning multiple pills. He had a			Address how the facility will identify oth	ıer	
		ed with water sitting next to			residents having the potential to be		
		Resident #78 stated the			affected by the same deficient practice	:	
	nurse always left his						
		the pills from the medication			Current facility residents have the		
	cup in his mouth and	swallowed them using the			potential to be affected by this deficient	t	
	water at his bedside	•			practice.		
					On 04/06/25 a 100% audit was comple	ted	
	An interview was co	nducted on 4/6/25 at 12:18			by the Director of Nursing and Assistar	ıt	
		lurse #2 said she was the			Director of Nursing for medications at		
	assigned nurse for F	Resident #78 and that she			bedside. No other variances identified.		
		s morning medications today.			On 04/15/25 Ad Hoc QAPI held to		
	•	d left his medications with			deficient practice and initiate a plan of		
		alert and oriented. Nurse #2			correction with auditing tools.		
		ght Resident #78 was able to			Address what measures will be put into)	
		nedications and had been			place or systemic changes made to		
		ninister his medication, but			ensure that the deficient practice will no	ot	
		d she had given Resident #78			recur:		
		thought he had taken them.			0 04/40/05 # B: 4 (N)		
		e gave Resident #78 his			On 04/16/25 the Director of Nursing	00	
		thank you, she went to			provided education to all licensed nurs	<i>=</i> 8	
	' '	tes medications, and she			and certified mediation aides on		
	assumed Resident #	#2 explained she did not see			medication administration policy, no	anı,	
		is medications. She did not			medications to be left at bedside. If at a time a resident would like to choose to	ırıy	
		ons she had given him but			self-administer the employee is to notif	v	
		een all his scheduled morning			the DON/ADON so that the appropriate	•	
		nedication administration			plan of care can be put into place.	•	
		#2 stated she should have			plan of oare oan be put into place.		
	` ′	to ensure Resident #78 had			No employee was allowed to work unti	l	
	taken his medication				education provided.		
		nducted with the Director of			Education added to General Orientatio	n	
	Nursing (DON) on 4/ stated Nurse #2 sho	/9/25 at 8:49 AM. The DON uld have stayed with			for all licensed nurses and certified medication aides.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		SURVEY PLETED
		345204	B. WING_			1	C / 14/2025
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2025
					55 VICTORIA ROAD		
STONECE	REEK HEALTH AND REH	ABILITATION			SHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F 761	Continued From page	e 39	F7	761			
F 701	Resident #78 and wa medications. She rep been assessed to sel The DON said medication with Resident #78 Nurse #2 had left Residual the bedside. An interview was con Administrator on 4/9/3 Administrator reporter medication administration administration ensure medications which by the resident prior to the room. She was not left the medications at 2. Resident #83 was 1/13/25. The admission Minimal 1/20/25 revealed that cognitively intact. There was not an assign self-administration do electronic medical reconstruction of the company of the self-administration do electronic medical reconstruction with self-administration do electronic medical reconstruction cup with self-administration cup filled on Resident #83's be stated that Nurse #5 morning and gave hir impatient and kept as	tched while he took his orted Resident #78 had not f-administer medications. ations should not have been 8. She was not sure why sident # 78's medications at ducted with the 25 at 1:56 PM. The d that the process for ation was for the nurse to were administered and taken to the nurse departing from the sure why Nurse #2 had at Resident #78's bedside. admitted to the facility on the number of the sure why Nurse #2 had at Resident #83 was the sessment for medication for the number of the sure why Nurse #3 dated with the sident #83's cord. Man observation and the sconducted with Resident #83's cord. Man observation and the sconducted with Resident revealed a plastic with yellow liquid medication did to table. Resident #83 came to his room that the his pills and she was very sking him over and over to Resident #83 took his pills		761	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing/designee will complete quality assurance monitoring medication administration with focus of medications at bedside. The audit will leas follows: 15 rooms 5x per week x 6 weeks, then 15 rooms 3x per week x 4 weeks, then 15 rooms monthly x 3 months. The Director of Nursing will report on the findings of the monitoring to the Quality Assurance Performance Improvement Committee during monthly QAPI meetified and will make changes to the plan as necessary to maintain compliance. Date of Compliance: 04/17/2025	of n pe ne	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345204	B. WING			C 4/14/2025
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		
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F 761	Continued From page	e 40	F 76	51		
	dated 3/9/25 through as administering any for the past 30 days. A review of Resident revealed an order for milliliter for hepatic et to be given at 12am, Further review of the	#83's April 2025 MAR lactulose liquid 10 grams/15 ncephalopathy (liver failure) 6am, 12pm and 6pm. MAR revealed Nurse #4 dose as administered on				
	conducted with Nurse she was instructed by Resident #83 took his Nurse #4 indicated shactulose. Nurse #4 we medication was on his Nurse #4 denied leave taking the lactulose and lactulose was observed. Continued review of MAR revealed the one of the was instructed.	n the morning. Nurse #3 medications as				
	9am for edema -Nadolol 10mg give 1 hypertension -neomycin 500mg giv for hepatic encephalo	ve 2 tablets (1000mg) at 8am				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345204	B. WING			C 4/14/2025	
	ROVIDER OR SUPPLIER	IABILITATION		STREET ADDRESS, CITY, STATE, ZIP COI 455 VICTORIA ROAD ASHEVILLE, NC 28801	•		
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F 761	Resident #83 would wanting his medication independently. Nurse doctor's order to leave When Nurse #5 was the past she would se medications which conduct with Same and Nurse #3. On 4/6/25 at 12:43 Paconducted with Nurse #3. On 4/6/25 at 12:43 Paconducted with Nurse Resident #83 came to medications. The number of the pills this morning and explained the lactulor Resident #83 by Nurninformed that an obsection of the pills and another lactulose on his beds going into Resident #83 had an with 5 pills and another lactulose on his beds going into Resident #83 came to the hall to get his medication came from and again the evening Nurse #4 that Resident #83 doctors.	e #5. She stated that argue with her about him on left for him to take e #5 stated that there was no we his medication at bedside. assigned to Resident #83 in tay with him until he took his build take as long as a half d that she was not assigned Resident #83's nurse was e #3. Nurse #3 stated that to her in the hall to take his urse stated she gave him his d not the lactulose. Nurse #3 se would have been given to se #4. Nurse #3 was ervation was made, and medication cup in his room her medication cup with the side table. Nurse #3 denied #83's room and then stated have left the pills in his room. M a second interview was e #3. She again stated that to the medication cart in the ations. She was unsure his that were in his room in stated it could have been 4. Nurse #3 was informed hereit receive 5 pills in the lated again he came to her ations on 4/6/25.	F 70	51			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	COMI	E SURVEY PLETED
		345204	B. WING _		1	C / 14/2025
	ROVIDER OR SUPPLIER	ABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	1 04	114/2023
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 761	that Resident #83 wadischarged from the form of the following as independently. Even alert and probably coindependently he shows an assessment. On 4/9/25 at 8:48 AN with the Director of North stated that both Nurshave stayed with Restake his medications, assessed to take his which he was not. The medications should not be stayed from the following should not be s	ledical Director. He stated is alert and was going to be facility soon. The Medical was not the best practice to a resident's room without sessed to take medications though Resident #83 was all take his medications build not be doing this without an interview was conducted ursing (DON). The DON is all the was and Nurse #4 should sident #83 and observed him unless Resident #83 was medications independently, is a DON said that ot be left with Resident #83. Nurse #3 and Nurse #4 left	F 7	61		
	with the Administrato that it was the nurse's resident takes his or leaving the room. The why Nurse #3 and Not Resident #83's bedsi Food Procurement, S CFR(s): 483.60(i)(1)(\$483.60(i) Food safe The facility must - \$483.60(i)(1) - Procu	tore/Prepare/Serve-Sanitary 2) ty requirements. re food from sources red satisfactory by federal,	F 8	12		4/17/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345204	B. WING _		C 04/14/2025	
	ROVIDER OR SUPPLIER	HABILITATION		STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	1 04/14/2020	
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 812	(i) This may include from local producers and local laws or re (ii) This provision do facilities from using gardens, subject to safe growing and for (iii) This provision do from consuming for serve food in accord standards for food serve food in accord standards for food serve food that we packaging in the dry facility also failed to scoop holders and to dates. These pract food served to reside Findings included: a. On 4/6/25 at 10:0 walk-in refrigerator (DM) found a sealer chopped celery with located on the seconduring the observation been removed and b. On 4/6/25 at 10:1 DM in the kitchen for bins on wheels with	food items obtained directly s, subject to applicable State gulations. Des not prohibit or prevent produce grown in facility compliance with applicable od-handling practices. Does not preclude residents dis not procured by the facility. Des, prepare, distribute and dance with professional service safety. IT is not met as evidenced sions and interviews with staff, remove expired food from 1 of the fors (walk-in refrigerator) and the product of the pro	F 8	F 812 Address how corrective action will accomplished for those residents have been affected by the deficier practice: The facility failed to remove expire from 1 of 3 kitchen refrigerators ar remove food that was past the use date in the dry storage area. The facility also failed to clean 3 o storage bin scoop holders and to I those bins with use by dates. The facility failed to date 4 loaves that were removed from the freeze 04/04/25 with used by date. On 4/06/25 the Dietary Manager of the pre-packaged celery the ref and the dry storage room. On 04/06/25 3 of 3 dry storage bin emptied and cleaned which includ scoop holder. Dry storage bins we re-stocked with dry food, labeled we have the storage of the pre-stocked with dry food, labeled we re-stocked we re-stocked with dry food, labeled we re-stocked with dry food, labeled we re-stocked we re	found to at a d food and abel abel ar on a disposed rigerator as were ed the are	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		STRUCTION		E SURVEY PLETED
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NAME OF T	TOVIDEN ON 301 1 EIEN				, , ,		
STONECR	EEK HEALTH AND R	EHABILITATION			TORIA ROAD		
				ASHEV	/ILLE, NC 28801		
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F 812	Continued From p	age 44	F 8	12			
	labeled sugar was of the kitchen and The sugar bin did use by date. The labeled rice were farea with each correct area with each correct and flour open date or use the attached scoop in was observed to debris in the botto was directly touch. The DM stated du sugar, flour and rice needed to have a the scoop holders every 30 days where	located in the food prep area was approximately 25% full. not contain an open date or a bin labeled flour and the bin found in the dry food storage nationer approximately 50% full. bins were not labeled with an oy date. Each bin had an a holder. Each bins' holder ontain food debris and other m of the holder. The scooping the bottom of each holder. ring the observation that the se were good for 30 days and use by date label. She stated and the bins were cleaned on the contents had expired.		fille On of b Add res affe Cui pot pra On con incl stoi	ed and labeled with use by date. 04/06/25 4 loaves of bread disposity the Dietary Manager. dress how the facility will identify didents having the potential to be exceed by the same deficient practice. Trent facility residents have the tential to be affected by this deficient cities. 4/06/25 the Dietary Manager mpleted a 100% audit of food storal luding refrigerators, freezers, and rage rooms to ensure all food was hin usage dates, properly stored, eled, and items were properly dispass identified.	ent age dry	
	storage area on 4/loaves of bread wi written on them. To observation the brifreezer and was tathe DM stated should have been also said the bread of the bread of the storage of the storag	with the DM in the dry food 16/25 at 10:23 AM found 4 th a use by date of 2/5/25 The DM stated during the ead had been stored in the aken out to be used on 4/4/25. The did not realize the bread downer removed from the stated on 4/9/25 at 2:03 PM should have been disposed of the stated with a use by date and cleaned. The Administrator do in the dry storage room when removed from the freezer.		On disc place ensured educe exp from censured educe educe exp from educe educe exp from educe educe educe educe exp from educe	employee was allowed to work unucation was provided. 4/15/25 an ad hoc QAPI was held cuss deficient practice and initiate in of correction with auditing tools. dress what measures will be put in ce or systemic changes made to sure that the deficient practice will cur: 04/15/25 the Dietary Manager was ucated by the Administrator on the process of the provided in the freezer it is to be dated uponoval from freezer. 04/15/25 the Dietary Manager was ucated by the Administrator on the process of the process of the provided in the freezer.	d to a nto not	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (XECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 812	Continued From pag	e 45	F8	to be labeled with date whe date the contents are to be The cleaning of the bins occempty and/or the contents as per the label, the scoop sholders are to be cleaned a bins are re-filled and/or visil. On 04/16/25 the Dietary stateducated by the Registered the following: Standard for I with a "pull date" when pulle freezer. Monitor produce date and daily, discard food that the date it out dates. And the date it out dates. Dry stoto be labeled with date when date the contents are to be The cleaning of the bins occempty and/or the contents as per the label, the scoop sholders are to be cleaned a bins are re-filled and/or visil. Indicate how the facility plan its performance to make su are sustained: The Dietary Manager/desig complete quality assurance food labeling dates/use by cinclude storage bin labeling cleanliness 5x week x 6 we per week x 8 weeks, then months. The Dietary Manager will refindings of the monitoring to Assurance Performance Im Committee during monthly of	to used by. cur when are out of dar storage nytime the bly soiled. If were I Dietician or abeling food ed from the ates on arriva is outdated of the "Use By food has orage bins a n filled and t to used by. cur when are out of dar storage nytime the bly soiled. Ins to monitor are solutions nee will monitoring of dates to and eks, then 3x nonthly x 2 eport on the to the Quality provement	de d		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345204	B. WING _			C 04/14/2025
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	1 0 11 11 12 12 1
STONECR	EEK HEALTH AND REH	ARII ITATION		455 VICTORIA ROAD		
OTORLOR	CERTICALITY AND INCID	ABILITATION		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG			DATE.
F 812	and will make changes to the plan as necessary to maintain compliance. The date of compliance is 4/17/25					
F 825 SS=J	Provide/Obtain Speci CFR(s): 483.65(a)(1)	alized Rehab Services (2)	F 8	25		4/15/25
	§483.65(a) Provision If specialized rehabilit not limited to physical pathology, occupation therapy, and rehabilit illness and intellectual lesser intensity as sel required in the reside care, the facility must §483.65(a)(1) Provide §483.65(a)(2) In accordation the required seresource that is a proven rehabilitative services participating in any ferograms pursuant to the Act. This REQUIREMENT by:	tative services such as but therapy, speech-language hal therapy, respiratory ative services for mental I disability or services of a troth at §483.120(c), are not's comprehensive plan of the required services; or or ordance with §483.70(f), ervices from an outside vider of specialized and is not excluded from deral or state health care section 1128 and 1156 of				
	Director, and Orthope facility failed to comm department an Occup referral ordered by Re Surgeon for evaluatio resident's right olecra 12/13/24 the resident reduction internal fixa	esident #63's Orthopedic in and treatment of the non (tip of the elbow). On underwent an open		Address how corrective accomplished for those have been affected by the practice: On 12/26/24 the facility communicate a therapy orthopedic provider for I have Occupational Therand treat the right elbow	residents found he deficient failed to referral from ar Resident #63 to apy (OT) evalu	n o

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BOILD	_		Ι,	С
		345204	B. WING			1	′ 14/2025
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2023
					55 VICTORIA ROAD		
STONECR	REEK HEALTH AND REH	IABILITATION			SHEVILLE, NC 28801		
	0.11.41.45.75.4.07	TATELLE OF DEFINITION	T				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 825	Continued From page	e 47	F	825			
	the bone and then ho	olding the pieces together			referral also had recommendations for		
		ates, screws, or rods). At			Resident #63 to wear the splint at all tir	nes	
	· ·	/-up appointment with the			except for hygiene purposes and gentle		
		on 12/26/24 he ordered OT			active range of motion exercise. Reside		
		ROM), pain and edema			#63 was not evaluated by OT until		
	(swelling caused by a	a buildup of fluid) control,			04/02/25. On 02/20/25 Resident #63		
	home exercise progra	am (HEP), and splint wear			returned to the orthopedic doctor's office	œ.	
	with removal for hygi	ene purposes and active			At the visit the splint was removed and	а	
		sident #63's splint was not			pressure ulcer over the medial aspect of	of	
		20/25 follow up appointment			the elbow with some limited range of		
		Surgeon and she was not			motion was noted. On 2/20/25 the Wou		
	-	I 4/2/25. Resident #63			Nurse received new wound care orders		
		e ulcers to the right elbow,			from the wound provider for Resident #	63.	
		for an infection with removal			On 02/25/25 the Wound Provider		
		erted surgical hardware, and			evaluated the wound and determined the	nat	
	treatment with intrave				it was a stage 3 and stage 4 pressure		
		nigh likelihood of suffering			ulcer and the orthopedic hardware was		
		sult of this failure. This			exposed. The Wound Provider instruct		
	deficient practice affer reviewed for therapy.				the staff to notify the Orthopedic doctor and provided new wound care orders.		
	reviewed for therapy.	•			03/26/25 Resident #63 required surger		
	Immediate jeonardy l	began on 12/26/24 when the			remove the exposed hardware and	y to	
		ment the OT referral that			returned to the facility on 04/01/25 on		
		val placing Resident #63 at			intravenous (IV) antibiotic for Methicillir	1	
	•	ment of pressure wounds			resistant staphylococcus aureus (MRS		
		liate jeopardy was removed			of the wound.	• • •	
		e facility implemented an			0.0000000000000000000000000000000000000		
		allegation of immediate			Address how the facility will identify oth	ıer	
		ne facility will remain out of			residents having the potential to be		
		er scope and severity level of			affected by the same deficient practice	:	
		th potential for more than					
		not immediate jeopardy) to			Because all residents with new orders	for	
		completed and monitoring			referrals to therapy services are at risk		
	systems put into plac	· · · · · · · · · · · · · · · · · · ·			when a physician's order is not followe		
	·				the following plan has been devised:		
	The findings included	i :			On 4/9/25 the Administrator and the		
					Director of Clinical Services reviewed a	all	
	Resident #63 was ad	lmitted on 11/29/23 with			resident orders with outside appointme	nts	
	diagnoses that include	led non-traumatic brain			in the past 90 days to ensure they were	e in	

I ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345204	B. WING				C 4.4/2025	
NAME OF DE	ROVIDER OR SUPPLIER	0.70207	1	ST.	REET ADDRESS, CITY, STATE, ZIP CODE	04/	14/2025	
NAME OF F	NOVIDER OR SUFFLIER							
STONECR	EEK HEALTH AND REH	ABILITATION			5 VICTORIA ROAD			
				A	SHEVILLE, NC 28801			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 825	Continued From page	e 48	F 8	25				
	and Alzheimer's disea	nsion, anxiety, depression, ase. erly Minimum Data Set			place and correct. No new issues were identified. No other referral orders for therapy were missing. On 4/9/25 the Therapy Director comple			
	, ,	4 indicated she had severe and required maximal			an audit of all current facility residents therapy orders to ensure the correct	with		
	assistance with upper	•			physician ordered treatment was in pla	ice.		
		esident #63 did not have any			All resident treatments were correct ar			
		l was not receiving any			matched the physician's order.			
	therapy.				Director of Nursing, Unit Manager's,			
					Minimum Data Set (MDS) Nurse, and			
		gency department (ED)			Medical Director conducted an Ad Hoo			
		3/24 revealed Resident #63			QAPI (Quality Assurance Performance	!		
		D after a fall and had a			Improvement) meeting to review and			
	_	ecranon. The discharge			determine root cause of the deficient			
		Resident #63 needed to			practice. By root cause analysis, the Q			
	see an orthopedic sp	ecialist within 10 days.			committee determined that the referral			
	A	10/C/04 at 11:00 AMittara			form was returned with Resident #63 of			
		12/6/24 at 11:08 AM written rsing (DON) indicated			12/26/24 but was not given to the nurs review. Instead, it was placed in the	e to		
		nsible party had consented			Medical Record folder to be uploaded	to		
		roup for the resident to have			the medical record. The	10		
	. •	ipper extremity (RUE) to			recommendations for an Occupational			
	repair her fracture on				Therapist referral and to take the splin	off		
		neduled with the surgery			for hygiene and active range of motion			
	• .	tion orders were received.			were not implemented. To address the			
	, ,				root cause the facility implemented			
	The hospital discharg	ge instructions dated			education on who will be responsible for	or		
	12/13/24 indicated Re	esident #63 had surgery for			ensuring the referral form is brought ba	ack		
	open reduction intern	al fixation. The discharge			to the facility when a resident has an			
		ollow up with the Orthopedic			outside appointment so new			
		, take pain medications as			recommendations or orders can be			
		as to be non-weight bearing			implemented. The Unit Manager will be			
	for operated limb (rigl	ht upper extremity).			responsible for ensuring the referral fo returns with the resident. If it is the	rm		
	An orthopedic progre	ss note dated 12/26/24			weekend or after the Unit Manager has	6		
	indicated Resident #6	63 was seen for follow-up 2			left, the hall nurse will be responsible.	The		
	week's status post op	en reduction internal fixation			transporter will notify the Unit Manager	the		
	of a right olecranon fr	acture. The resident was			resident is back from the appointment	and		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345204	B. WING				C / 14/2025
NAME OF P	ROVIDER OR SUPPLIER	0.020.	 	ST	REET ADDRESS, CITY, STATE, ZIP CODE	04/	14/2025
TVAIVIL OF T	TOVIDER OR OUT FILE						
STONECR	EEK HEALTH AND REH	ABILITATION			5 VICTORIA ROAD		
				AS	SHEVILLE, NC 28801		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 825	Continued From page	e 49	F 8	325			
	orthosis (an external splint) for her right up orthopedic office occoccupational therapis and her caregiver we and provide care for note indicated to con	upational therapist. The st indicated Resident #63 re educated on how to wear the orthosis. The progress tact the occupational therapy			will give her any paperwork at that time there is no referral form, the Unit Mana will call the physician office to obtain a copy of the form. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will n	nger D	
	care and to follow su orthosis. The surgica along the posterior a elbow. Gentle range not cause any signific	· ·			recur: On 4/9/25, the Director of Clinical Services provided education to the Administrator, DON, Transportation dri and ADON that included the following: A) The transportation driver will notify t Unit Manager or hall nurse the residen has returned from the outside appointment, the Unit Manager will be	he	
	12/26/24 had been so health record on 1/2/2 "medications and trea orthopedic information "consults" tab. The resident to be evaluated olecranon ORIF with control, modalities, a program). Resident splint at all times excand gentle AROM (and exercises 1 to 2 times. An Orthopedic Surget 02/20/25 indicated Refor a follow-up of her Orthopedic Surgeon resident on 12/26/24.	Surgeon referral order dated canned into Resident #63's			responsible for obtaining a completed referral form or encounter notes from the appointment visit. For appointments/E visits occurring on weekends the hall nurse will be responsible for obtaining reviewing the referral. B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy. C.) The DON will have a list of daily resident appointments and will follow with the Unit Managers daily to ensure referral forms have been returned and reviewed, with any new orders entered into the medical record. D.) Nurse Aides that accompany a	R and e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		Ι,	C	
		345204	B. WING			1	_ 14/2025	
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CTONECE	DEEK HEALTH AND DE	HARU ITATION		45	55 VICTORIA ROAD			
STONECH	REEK HEALTH AND RE	HABILITATION		Α	SHEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 825	saw her. The progresident had been with enursing aide with been taking it off du the splint, the Orthonoticed a pressure of closest to the body) limited elbow range had steri-strips on hwith the Orthopedic concerned him as to whether she had be splint to work with the questioned if she st (anti-microbial agents surgical site) on her definitely had scaly Orthopedic Surgeor discontinuing her specificationally, he individually he individually he individual from the hadditionally, he individual from the concern for exposed wanted to be called became infected. A nurse's note dated by Nurse #2 indicated back from her orthonelastic bandage was secondary to remove splint was removed have a small open a measuring approximal.	ess note indicated the vearing the splint at night and h her said the resident had ring the day. Upon removing pedic Surgeon indicated he wound over the medial (area aspect of the elbow with of motion. Resident #63 still her elbow from the last visit. Surgeon and he wrote that it of the hygiene of this area and hen spending time out of the herapy. He wrote that he hill had surgical preport used in preparation of a shands and indicated she skin in the area. The hindicated he was completely blint device and ordered medial elbow wound. Cated the medial elbow wound her surgical incision and did. He noted there was no do hardware in her elbow and right away by the facility if it and 2/20/25 at 5:54 PM written hed Resident #63 had arrived pedic appointment with an ap and cast padding on RUE and of her splint. When the pedic appointment with an ap and cast padding on RUE and of her splint. When the pedic appointment with an ap and cast padding on RUE and of her splint. When the pedic appointment with an ap and cast padding on RUE and of her splint. When the pedicated her right elbow mately 0.8 cm (centimeters) x both with rusty discoloration	F	325	resident to an outside appointment are there to care for the resident. The Transportation Driver will be responsibl for ensuring any paperwork, and the referral form, are returned to the Nurse Manger or hall Nurse. E.) On 4/9/25 the Unit Manager was educated that when a family member signs the resident out for an outside appointment, they are to follow up with family when they sign the resident back into the facility to ensure all paperwork has been given to the nurse for review. F.) Unit Managers, or designee will be responsible for taking any therapy refer orders for new admissions to the therap department on the day of admission. On 4/9/25 DON and ADON provided education to all facility Licensed Nurses and Nurse Aides that included the following: A) Unit Manager, or designee, will be responsible for obtaining a completed referral form or encounter note from the appointment visit. For appointments/El visits occurring on weekends, the hall nurse will be responsible for obtaining a reviewing the referral. B.) Unit manager, or designee, will be responsible for entering orders and ensuring any therapy referrals are received by therapy. For appointments/ER visits occurring on the weekends, the hall nurse will be responsible for entering orders and ensuring any therapy referrals are received by therapy. C.) Nurse Aides that accompany a	the c cral by s		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345204	B. WING _				C / 14/2025
NAME OF PR	ROVIDER OR SUPPLIER		<u>'</u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				4	55 VICTORIA ROAD		
STONECR	EEK HEALTH AND REH	ABILITATION		Α	SHEVILLE, NC 28801		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX				(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
F 825	Continued From page	e 51	F 8	325			
	The resident complai	ned of mild pain when			there to care for the resident. The		
	palpation (touched wi	ith hand) was performed but			Transportation Driver will be responsib	le	
	pain resolved once the	ne stimulus was removed.			for ensuring any paperwork and the		
	Resident #63 was ob				referral form are returned to the Unit		
		aling tissue expanding			Manager or hall Nurse.		
	•	ssue above the ulcer. The			D) The DON will have a list of daily		
		notified and new orders			resident appointments and will follow u	p	
		reatment administration			with the Unit Managers every day to		
	` , .	dated, and new orders were			ensure all referral forms have been		
	carried out.				returned and reviewed, with any new		
					orders entered into the medical record.		
		m the Orthopedic Surgeon			E.) On 4/9/25 the Unit Manager was		
	on 2/26/25 indicated				educated that when a family member		
		ram 2 times daily by mouth			signs the resident out for an outside	tha	
	101 21 days for media	I elbow pressure wound.			appointment, they are to follow up with		
	A progress note date	d 02/28/25 from the			family when they sign the resident back into the facility to ensure all paperwork		
	· -	indicated Resident #63 was			has been given to the nurse for review.		
	seen for a follow-up of				F.) Unit Managers, or designee will be		
		#63 was treated with open			responsible for taking any therapy refe	rral	
		I fixation on 12/13/24. The			orders for new admissions to the thera		
		wrote Resident #63 had			department on the day of admission.	Py	
	-	s week and was able to take			The current facility Licensed Nurses ar	ıd	
	•	her moving. The Orthopedic			newly hired nurses not receiving		
		not think Resident #63 had			education on 4/9/25 will not be allowed	to	
	~	t the skilled nursing facility			work until the education has been		
	•	II in place. Resident #63			completed. The DON will utilize an acti	ve	
	·	today at the Orthopedic			employee list to track completion of		
		cause he received a call			education and validate the post educat	ion	
	from Resident #63's	Wound Nurse who stated			written test was completed and passed		
	the medial elbow wou	und was healing but the			This responsibility was communicated	to	
	wound over the poste	erior aspect of the elbow had			the DON by the Administrator on 4/9/2	5.	
		ould see the plate at the			Education will also be included during		
		The wound over the medial			orientation for newly hired facility Licen		
		uite nicely and there was a			Nurses, Nurse Aides, and Transportation		
	•	sent over the olecranon with			drivers, to be completed by Director of		
	_	us explain fluid coming from			Nursing or Nurse Manager.		
		that he did think he saw			Indicate how the facility plans to monitor		
	Resident #63's olecra	anon plate in the base of the			its performance to make sure solutions		

		IDENTIFICATION NI IMBED:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
		345204	B. WING _				С	
		345204	B. WING _			04	1/14/2025	
NAME OF P	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE			
STONECE	REEK HEALTH AND REH	ARII ITATION		455	VICTORIA ROAD			
STONEON	CERTICALITI AND INCIT	ABILITATION		AS	HEVILLE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 825	Continued From page	÷ 52	F 8	325				
F 023	wound. The note includoxycycline antibiotic for 21 days prescribe Orthopedic Surgeon in 3 weeks. He wrote need to be removed in The Orthopedic Surga 3/26/25 and signed a Resident #63 returne facility had noticed on increasing redness, sher elbow wound. Rean infection going down hardware) and in the fluid-filled sac located was completed and the reviewed the x-ray arrindication of osteomy prominence. The Orthote they should produce they should produced for irrigation, down removal. This will allusted the hospir postoperatively and for treatment to the residual A nurse's note writter Nurse #3 indicated R her appointment at the scheduled surgery for (03/26/25). The residual notified and consent where the service is the hospital on 03/26/25 to the hosp	aded an order for 100 milligrams twice daily d on 02/26/25. The wanted her to be seen again that the hardware might of the wound did not heal up. eon's progress note dated to the clinic today. The er the past few days welling and draining from esident #63 had developed wn to her plate (surgical olecranon bursa (a small, at the olecranon). An x-ray ne Orthopedic Surgeon and wrote he did not see any elitis from the elbow's bony nopedic Surgeon went on to eved to the operating room ebridement and hardware ow the resident to be tal for IV antibiotics and or him to better provide eent moving forward. I on 03/26/25 at 1:30 PM by esident #63 returned from e orthopedic office with r hardware removal today ent's responsible party was	F8		are sustained: The DON/Designee will complete quality assurance monitoring of outside reside appointments to ensure accuracy, and referral forms followed up on. Monitoring of referral forms will be completed 5x pweek during clinical meeting x 8 weeks 3x per week x 6 weeks, then weekly x weeks and as necessary thereafter. The Director of Nursing will report on the findings of the monitoring to the Quality Assurance Performance Improvement Committee during monthly QAPI meeting and will make changes to the plan as necessary to maintain compliance. Date of compliance is 4/15/25	nt all ng eer s, 4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345204	B. WING				C 14/2025
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2025
					VICTORIA ROAD		
STONECE	REEK HEALTH AND I	REHABILITATION			HEVILLE, NC 28801		
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(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 825	Continued From p	page 53	F	325			
	admitting hospital	ist wrote Resident #63 was					
		orthopedic office with a swollen					
		(red and swollen) right elbow					
		pery on 3/26/25. Resident #63					
	was admitted pos	toperatively and given IV					
	antibiotics for MR	SA (Methicillin-Resistant					
	Staphylococcus a	ureus). The hospital discharge					
	summary dated 0	4/01/25 read Resident #63 was					
	to receive PT or 0	OT 2 to 4 days week. The					
		ve IV antibiotics via PICC					
		rted central catheter, is a long,					
		serted through a vein in your					
		hrough to the larger veins near					
	, ,	wound dressings were to remain					
		opedic Surgeons follow up					
		e discharge summary included					
		ith IV vancomycin 1 gram every					
		nd and bone infection and end tional orders read to assist with					
		n every Monday for vancomycin					
		R, BMP, and CBC. Furthermore,					
		be non-weight bearing to					
		t to follow-up with the					
		on on 4/16/25 at 10:45 AM.					
	A nurses note dat	ed 04/01/25 written by Nurse #2					
		nt #63 was re-admitted to the					
	facility on 04/01/2	5 at 2:20 pm. Resident #63 was					
		al on 03/26/25 from the					
	orthopedic office	due to a right elbow infection.					
	The resident was	taken into emergency surgery					
		debridement of her right elbow					
		noval. Resident #63 was					
		g to the right arm, splint was to					
	-	nd dry until follow-up, if splint got					
		be made to the Orthopedic					
		tely. Resident #63 had a midline					
		catheter inserted into the upper					
	arm) placed in he	r right upper chest and received					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345204	B. WING _			1	C 1 4/2025	
	ROVIDER OR SUPPLIER	ABILITATION		455 VICTO	DDRESS, CITY, STATE, ZIP CODE RIA ROAD LE, NC 28801			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 825	Continued From page vancomycin (antibioti until 05/08/25. A physician order writh #63 indicated vancon gram/200 milliliters in methicillin-resistant S (MRSA). Infuse over per hour PICC (thin to the upper arm that ex leading to the heart) funtil 05/08/25. The medical record renot seen by OT at the order from the Orthop. The DON verified in a 3:50 PM that Resider orthopedic appointment the splint was removed Surgeon, he found a splint. The DON state removed from 12/26/2. Transportation Aide to splint was not suppost reason. The DON incomplete in the splint was not suppost reason. The DON incomplete in the splint was not suppost reason. The DON incomplete in the splint was not suppost reason.	tten on 04/01/25 for Resident hycin-diluent combo 1 travenous for right elbow taphylococcus aureus one hour with 200 milliliters ube inserted into a vein in tends into a larger vein to right chest, every 12 hours evealed Resident #63 was a facility after the 12/26/24 bedic Surgeon until 04/02/25. In interview on 04/07/25 at 18 a		325				
	seen the referral order were separate docum scanned into the electronic different tabs. The Dorthopedic progress in the orthopedic OT and The DON stated in in PM that she was not office referral order d	er. She explained these						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		345204	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER	040204		STREET ADDRESS, CITY, STATE, ZIP (•	4/14/2025
				455 VICTORIA ROAD		
STONECE	REEK HEALTH AND F	REHABILITATION		ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 825	Continued From p	age 55	F 8	325		
	The DON stated to Surgeon should he the nurse who we returned from the the order should he #63's chart in with The DON said not outside provider we Transportation Aid sometimes appoin medical records by records would see notes and then given urse. The DON referral order was Transportation Aid the order. She expecause the reference to delivered to he she returned to the aware of the order.	and active range of motion. the order from the Orthopedic ave been read and reviewed by as working when the resident appointment (Nurse #7), and the orthopedic information. The orthopedic informatio				
	interview. The Orthopedic S phone of 04/09/25 Resident #63 was office with a fractuand had surgery to 12/13/25. The Or saw Resident #63 appointment. He Resident #63's spand active range of occupational there Orthopedic Surge	urgeon was interviewed via 5 at 3:30 PM. He stated his patient and had come to his ured right olecranon on 12/05/24 to stabilize the fracture on thopedic Surgeon stated he on 12/26/24 for a follow-up stated in his notes he ordered lint to be removed for hygiene of motion therapy with apy in the resident's facility. The on said hygiene included at to look for skin breakdown				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED		
			A. BOILD	_		، ا	3
		345204	B. WING				_ 14/2025
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2025
	101.52.1 01.1 00.1 12.2.1				55 VICTORIA ROAD		
STONECR	EEK HEALTH AND RE	EHABILITATION			ASHEVILLE, NC 28801		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 825	an elbow splint to months because the stiff. He said Residementia and need and was not able to Resident #63 could care for her splint whygiene and active the Orthopedic Surreceive occupation active range of mot times per week and Resident #63's facil Aide. He said he retarnsportation Aide appointments and I Resident #63 need stated he reviewed Transportation Aide appointment with he said Resident #63's and should have be therapy as he orde went on to say the Resident #63's elbodirectly to the splint 12/26/24 until 02/20 susceptible to deve comorbidities Resident removing the splint increase the ris	diditionally, he would not order emain on the resident for 2 e elbow could become very lent #63 had a diagnosis of led assistance with the splint of advocate for herself. I not be relied on by herself to which included removing it for range of motion. On 12/26/24 geon ordered Resident #63 to all therapy in her facility for cition and hygiene for 1 to 2 do the orders were sent to lity with the Transportation excalled the resident having a se with Resident #63 at the fine told her about the care ed along with his orders. He	F	825	DEFICIENCY)		
	04/08/25 at 4:58 Pt receive a referral fo	tor was interviewed on M. She stated she did not or Resident #63 to be te treatment until 4/2/25. She					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
			A. BOILD	NG _		١ ,	С
		345204	B. WING				′14/2025
NAME OF PROVIDER OR S	JPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
STONECREEK HEALT	I AND REH	ARII ITATION		4	55 VICTORIA ROAD		
OTONZONZEN HEXEN	.,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Α	SHEVILLE, NC 28801		
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
was not dit the elbow is said the sp changed to hygiene ca provider. seen a the occupation evaluate th indicated of care for the treatment, splint woul order. The Resident # splint and infection. Si be used to Therapy D removed th flow would stated she and blood of a pressu it was a co nursing to care neede progressio say she re providers i notes or di been giver Director st	splint on R ficult to rerand arm stand arm stand arm stand arm stand arm stand arm stand are with again and the reference of the resident of the resident stand st	desident #63's arm and elbow move and was used to keep able. The Therapy Director might have been able to be splint to allow for easier reement from the orthopedic py Director said had she all for Resident #63, an at would have been sent to specifically for the need ral. Resident #63's plan of d then be developed for her sident's hygiene under the en done per the treatment Director said hygiene for would include removing the ne skin for integrity or pap and a washcloth would skin. Additionally, the d when the splint was the range of motion and blood ted. The Therapy Director ent #63's range of motion have helped reduce the risk from developing. She stated between therapy and resident was receiving the esident's therapy erapy Director went on to rapy referrals from outside ways such as progress all orders that would have nursing. The Therapy id think Resident #63 should ne therapist in the facility for	F	825			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		345204	B. WING _			C 04/14/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 455 VICTORIA ROAD ASHEVILLE, NC 28801	CODE	04/14/2023	
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 825	Resident #63 was lass September 2024 and until 04/02/25. The THEP as written on the referral meant for the help with range of me #63 had a diagnosis have been able to do The Medical Director phone on 04/08/25 a normally a copy of no outside provider wour review by a nurse, the doctor's book for him did not recall seeing therapist referral for I orthopedic office in Dwent on to say the Oshould have been red DON and then scann medical record for the expected orthopedic facility. The Administrator was 2:03 PM and stated to referral orders from 1 reviewed and the order.		F	325	CY)		
	The facility's Adminis Immediate Jeopardy The facility provided allegation of immedia	on 04/09/25 at 5:15 PM. the following credible ate jeopardy removal:					
	Identity those resider	nts who have suffered, or					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345204	B. WING			C)4/14/2025		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 455 VICTORIA ROAD ASHEVILLE, NC 28801		4/14/2025		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 825	result of the noncondon 12/26/24 the fact therapy referral from Resident #63 to have evaluate and treat the referral also had red #63 to wear the spling hygiene purposes a motion exercise. Responding to the orthousit the splint was rover the medial asplimited range of motion the Wound Nurse resorders from the wound on 02/25/25 the Wound and determinating 4 pressure ulchardware was exponinstructed the staff thand provided new would not would not would not be staffed the facility on 04/01 antibiotic for Methic aureus (MRSA) of the Resident #1	rious adverse outcome as a inpliance: cility failed to communicate a in an orthopedic provider for ive Occupational Therapy (OT) the right elbow fracture. The commendations for Resident int at all times except for indigentle active range of esident #63 was not evaluated 5. On 02/20/25 Resident #63 opedic doctor's office. At the emoved and a pressure ulcer ect of the elbow with some cion was noted. On 02/20/25 eceived new wound care and provider for Resident #63. Out Provider evaluated the ned that it was a stage 3 and cor and the orthopedic sed. The Wound Provider on notify the Orthopedic doctor in it is incompared to	F 8					
	physician's order is has been devised: On 04/09/25 the Ad Clinical Services rev outside appointmen	not followed the following plan ministrator and the Director of viewed all resident orders with ts in the past 90 days to place and correct. No new						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345204	B. WING _			C 04/14/2025		
NAME OF PROVIDER OR SUPPLIER STONECREEK HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		04/14/2023		
(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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 825	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	325				
	with the resident. If i Unit Manager has le	ring the referral form returns t is the weekend or after the ft, the hall nurse will be nsporter will notify the Unit						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		345204	B. WING _			C 04/14/2025		
	NAME OF PROVIDER OR SUPPLIER STONECREEK HEALTH AND REHABILITATION			STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801		341442020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	(X5) COMPLETION DATE			
F 825	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F8	· ·				
	outside appointmen resident. The Trans responsible for ensu	t accompany a resident to an tare there to care for the portation Driver will be uring any paperwork, and the turned to the Nurse Manger or						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345204	B. WING _			C 04/14/2025		
NAME OF PROVIDER OR SUPPLIER STONECREEK HEALTH AND REHABILITATION			•	STREET ADDRESS, CITY, STATE, ZIP CODE 455 VICTORIA ROAD ASHEVILLE, NC 28801	•	04142020		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPLETION			
F 825	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F					
	outside appointmen resident. The Trans responsible for ensi	t accompany a resident to an t are there to care for the portation Driver will be uring any paperwork and the urned to the Unit Manager or						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345204	B. WING			C 04/44/2025		
NAME OF PROVIDER OR SUPPLIER STONECREEK HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP CODE 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	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 825	Continued From pag	e 63	F 8	325				
	`							
	Alleged Date of Imm	ediate Jeopardy Removal:						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345204	B. WING _				C 14/2025
NAME OF PROVIDER OR SUPPLIER STONECREEK HEALTH AND REHABILITATION				STREET ADDRESS, CITY, STATE, ZIP 455 VICTORIA ROAD ASHEVILLE, NC 28801	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE
F 825	jeopardy removal plather facility's QAPI meause of the deficient held on 4/9/25 and in Medical Director, DC Worker, Therapy Director of Clinical Swere both verified as review of every residucations from the patherapy to ensure the treatment was in platherapy to ensure the treatment was in platherapy to ensure the treatment was in platherapy to ensure the treatment was in platherapy. Education was indicated in the remoducation of the conducted on 4/9/25 nurses, nursing aide complete by reviewing sheet and staff intervincluded a test that earn daysed, and earn completion and under Furthermore, the education or intervince and to orientation	the facility's immediate an was completed on 4/14/25. Ineeting to determine a root at practice was verified to be included the Administrator, DN, Dietary Manager, Social ector, MDS nurse, floor derations Manager, and dervices. The 4/9/25 audits a completed to include a dent's appointment dates and ast 90 days and the orders for decorrect physician ordered are for all disciplines (PT, OT, conducted on 4/9/25 as a dient's appointment dates and ast 90 days and the orders for decorrect physician ordered are for all disciplines (PT, OT, conducted on 4/9/25 as a dient's appointment of the Administrator, DON, and ADON. Additional decorrect physician was verified as and the education was verified as and the education signature with the dienticipant completed and participant had signed derstanding of the education. Lucation was verified to be	F8	325			