A. BUILDING ____________________________

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345204

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

07/01/2017

DATE

(rs) MULTIPLE CONSTRUCTION

STREET ADDRESS, CITY, STATE, ZIP CODE

455 VICTORIA ROAD

ASHEVILLE, NC  28801

C.

NAME OF PROVIDER OR SUPPLIER

STONECREEK HEALTH AND REHABILITATION

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

345204

07/01/2017

C

STREET ADDRESS, CITY, STATE, ZIP CODE

455 VICTORIA ROAD

ASHEVILLE, NC  28801

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ELECTRONICALLY SIGNED

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.