STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345204	A. Building B. Wing	06/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonecreek Health and Rehabilitation	455 Victoria Road Asheville, NC 28801

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and staff interviews, the facility failed to ensure a Dietary Aide with facial hair wore a facial hair covering while handling and preparing food in the kitchen for 1 of 4 Dietary Aides observed (Dietary Aide #1). This practice had the potential to contaminate food served to residents. The findings included:On 6/16/26 at 11:19 AM, Dietary Aide #1 was observed removing a tray of rolls from the oven, placing the tray on a workstation, and applying butter to the rolls. Dietary Aide #1 had facial hair (beard and mustache) and was not wearing a facial hair covering. His facial hair was approximately a quarter of an inch in length. During an interview on 6/16/26 at 11:21 AM, Dietary Aide #1 reported he knew he should have been wearing a facial hair covering and forgot to put one on before handling food. An interview on 6/16/26 at 11:22 AM with the Dietary Manager revealed Dietary Aide #1 should have been wearing a facial hair covering and that dietary staff were expected to wear the appropriate hair covering while preparing food.An interview on 6/17/26 at 1:39 PM with the Administrator revealed staff should wear the appropriate hair coverings whenever involved in food preparation to prevent food contamination.

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.

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews with resident, family member, staff and Physician Assistant, the facility failed to prevent urinary catheter bags from touching the floor to reduce the risk of infection for 2 of 2 residents (Resident #2 and Resident #72) reviewed for urinary catheters. The findings included: 1. Resident #2 was admitted to the facility on [DATE] with diagnoses that included obstructive and reflux uropathy (blockage that causes urine to back up). Resident #2's care plan started on 4/28/26 indicated Resident #2 required a suprapubic urinary catheter related to obstructive uropathy. Interventions included to position bag below level of bladder. The admission Minimum Data Set assessment dated [DATE] indicated Resident #2 was cognitively intact, had no rejection of care behaviors and had an indwelling catheter. Resident #2 was frequently incontinent of bowel. An observation was made of Resident #2 on 6/14/26 at 2:44 PM while he was lying in bed in his room. Resident #2 had an indwelling catheter connected to a catheter bag which was lying flat on the floor. Another observation was made of Resident #2 on 6/15/26 at 8:41 AM while he was lying in bed in his room. Resident #2's catheter bag which was connected to his indwelling catheter was lying flat on the floor on the left side of his bed. During an observation of incontinence care on Resident #2 on 6/15/26 at 1:03 PM with his family member present, Nurse Aide (NA) #2 walked over to the left side of Resident #2's bed after the procedure to pull the trash bag out of the trash can. Resident #2's catheter bag was lying flat on the floor on the left side of his bed. Without taking Resident #2's catheter bag off the floor, NA #2 proceeded to remove her gown and placed trash in the trash bag and exited Resident #2's room. An interview with Resident #2 and his family member on 6/15/26 at 1:10 PM revealed staff did not always pay attention to how his catheter bag was positioned and whether it was off the floor. Resident #2's family member stated that the staff did not always hook Resident #2's catheter bag on the frame of the bed so it could be off the floor. She stated she sometimes observed Resident #2's catheter bag lying flat on the floor. A follow-up interview with Resident #2 on 6/15/26 at 2:20 PM revealed he always kept an eye on his catheter bag to make sure he had urine output and whether it needed to be emptied or not. Resident #2 stated that he wanted the staff to keep an eye on his catheter bag, but they don't always do that. Resident #2 stated that some staff would place the catheter bag on the bed frame whenever they notice that the catheter bag was on the floor, but some would just ignore it. An interview with NA #2 on 6/15/26 at 1:14 PM revealed this was the first time she went into Resident #2's room when she had to provide incontinence care to him. NA #2 stated that she was just helping change him because his regular nurse aide went on break, and he had his call light on and told her that he needed to be changed. NA #2 stated that she did not notice the catheter bag on the floor (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	whenever she went to pick up the trash bag on the left side of Resident #2's bed. NA #2 stated that if she had observed the catheter bag on the floor, she would normally hook it up to the bed frame and that the catheter bag should be positioned off the floor. An interview with NA #3 on 6/15/26 at 2:18 PM revealed she was assigned to Resident #2, and she had gone in his room at least twice this morning when she did her rounds, but she couldn't remember the specific times she went in Resident #2's room. NA #3 stated that she did not notice Resident #2's catheter bag being on the floor. An interview with Nurse #2 on 6/15/26 at 1:38 PM revealed Resident #2 must have accidentally hit his catheter bag off the bed and onto the floor. Nurse #2 stated that she observed Resident #2's catheter bag on the floor when she went in the room at 7:45 AM to give his morning medications. Nurse #2 stated that she picked the catheter bag off the floor and hooked it to Resident #2's bed frame. Nurse #2 stated that she also took care of Resident #2 on 6/14/26, but she did not remember observing his catheter bag on the floor. Nurse #2 shared that it was easy not to notice Resident #2's catheter bag especially if staff stayed on the right side of the bed since his catheter bag often was positioned on the left side of the bed. Nurse #2 added that Resident #2 asked her to re-arrange his covers, so she had to go to the left side of his bed where she observed Resident #2's catheter bag on the floor. Nurse #2 further stated that Resident #2's catheter bag should be positioned off the floor, and she needed to tell the nurse aides to keep an eye on his catheter bag. An interview with the Director of Nursing (DON) on 6/16/26 at 1:20 PM revealed she had never seen Resident #2's catheter bag on the floor, and that it was usually hanging by the foot of the bed. The DON stated that whenever staff went into Resident #2's room, they should glance over and look at his catheter bag and make sure that it was not touching the floor for infection control purposes. A follow-up interview with the DON on 6/16/26 at 3:04 PM revealed Resident #2's catheter bag should be below the level of the bladder but not on the floor. The DON shared that Resident #2's family member had frequently moved Resident #2's catheter bag and once two weeks ago, she put it on the bed. The DON stated that the family member probably did not want to put her legs against the catheter bag whenever she sat to visit Resident #2. The DON added that they had educated Resident #2's family member that the catheter bag was supposed to be below his bladder but not on the floor and she agreed. The DON reported that she had not noticed the family member move his catheter bag since then. The DON further stated that Resident #2 moved his bed up and down with his bed remote control and often adjusted his positioning in the bed so the bag could have fallen off during repositioning. An interview with the Physician Assistant (PA) on 6/17/26 at 10:19 AM revealed she hadn't observed Resident #2's catheter bag being on the floor, and that it was usually hanging by the side of his bed. The PA stated that Resident #2's catheter bag should be positioned off the floor for infection control and sanitary reasons. 2. Resident #72 was admitted to the facility on [DATE]. His diagnoses included obstructive uropathy (blockage in the urinary tract that slows or stops urine flow). A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #72 had severe cognitive impairment. He was documented on the MDS as having an indwelling catheter. Resident #72 had a care plan last revised on 6/3/26 for an indwelling urinary catheter. The care plan (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	goal included catheter care to be managed appropriately, not to exhibit signs of urinary tract infection (UTI), or urethral trauma. The care plan interventions included catheter per order, changing catheter per order, and reporting signs of UTI. An order dated 5/25/26 was in place for an indwelling urinary catheter related to chronic obstructive uropathy. An observation was conducted on 6/15/26 at 11:08 AM of Resident #72 in his room in bed. His bed was in a lowered position. He was observed to have an indwelling urinary catheter draining to a bedside drainage bag. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. The catheter bag was observed to be resting on the floor. A follow up observation was conducted on 6/15/26 at 1:09 PM of Resident #72's indwelling urinary catheter drainage system. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. The catheter bag was observed to be resting on the floor. An interview was conducted with Nurse Aide (NA) #1 on 6/15/26 at 1:30 PM. She said she was assigned to care for Resident #72 today (6/15/26). She stated Resident #72 had refused to get up out of bed today. She reported she typically checked on his catheter throughout the shift. NA #1 stated she thought she had last checked on Resident #72 around 11:00 AM before she had gone to the dining room to help with lunch. She reported she had pulled him up in bed and assisted him to sit up on the side of his bed for lunch. NA #1 recalled his catheter bag was hanging on the side of his bed on the bed frame but thought there had been clearance between the bag and the floor. NA #1 observed Resident #72's catheter bag and confirmed it was resting on the ground. NA #1 thought either Resident #72 or another staff member might have lowered his bed causing the catheter bag to be on the floor. NA #1 said catheter bags should not be on the floor because of contamination. An interview was conducted with Nurse #3 on 6/15/26 at 1:38 PM. Nurse #3 reported she was Resident #72's assigned nurse today. She stated she had last been in Resident #72's room to check on him around 1:00 PM. Nurse #3 did not remember his catheter bag being on the floor when she was in his room checking on him. Nurse #3 said catheter bags should not touch the floor because of germs and contamination. An interview was conducted with the Director of Nursing (DON) on 6/16/26 at 1:20 PM. The DON stated urinary catheter bags should not touch or rest on the floor because of germs and to prevent contamination. The DON explained that when a resident was in bed, urinary catheter bags should be hung on the side of the bed below the level of the bladder, and the drainage bag should be off the floor. The DON explained Resident #72 could adjust his bed up and down with the bed remote. She thought Resident #72 had lowered his bed causing his catheter bag to be on the floor. An interview was conducted with the Administrator on 6/17/26 at 1:32 PM. The Administrator reported urinary catheter drainage bags should not be touching or resting on the floor for infection control reasons. She explained the urinary drainage bag should be hung on the bed frame and positioned below the level of the bladder but should not be touching the floor.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and interviews with staff and the Physician Assistant, the facility failed to maintain a medication error rate of less than 5% as evidenced by the omission of a medication and the administration of the wrong dosage (2 medication errors out of 33 opportunities), resulting in a medication error rate of 6.06% for 1 of 4 residents (Resident #100) observed during medication pass.The findings included:Resident #100 was admitted to the facility on [DATE] with diagnoses that included anemia, muscle weakness and depression.The physician's orders in Resident #100's electronic medical record indicated active orders for:2/25/26 - B Complex Plus Vitamin C one tablet oral once a day (supplement).4/19/26 - Sertraline (an antidepressant) 25 milligrams (mg) 3 tablets oral once a day for depression. Administer with 100 mg tablet to equal 175 mg.On 6/16/26 at 8:21 AM, Medication Aide (MA) #1 was observed as she prepared Resident #100's medications. MA #1 prepared a total of 6 pills in a medication cup for Resident #100 to take. The 6 pills consisted of one tablet of Calcium, one tablet of Losartan, one tablet of Memantine, one tablet of Nebivolol, one tablet of Sertraline 100 mg and one tablet of Sertraline 25 mg. The cup of pills did not include a tablet of B Complex Plus Vitamin C. At 8:27 AM, MA #1 walked to the dining room with Resident #100's medications in hand and observed Resident #100 eating in the dining room. MA #1 walked out of the dining room and asked the Unit Manager what to do with Resident #100's medications. The Unit Manager instructed MA #1 to label the cup of Resident #100's medications with his name and place in the top drawer of the medication cart until Resident #100 was finished eating in the dining room. MA #1 proceeded to walk to the medication cart, labeled the medication cup with Resident #100's name and secured it in the top drawer of the medication cart.On 6/16/26 at 9:00 AM, MA #1 assisted Resident #100 out of the dining room after he was finished eating breakfast and moved him in front of the medication cart in his wheelchair. MA #1 retrieved the cup of pills labeled with Resident #100's name in the top drawer of the medication cart and started to administer the medications to Resident #100. Right before administering the cup of pills, MA #1 was asked to count the number of pills in Resident #100's medication cup and MA #1 counted a total of 6 pills as she had prepared earlier. At 9:05 AM, Resident #100 was observed taking the 6 pills from the medication cup as given by MA #1.On 6/16/26 at 9:08 AM, an interview with MA #1 revealed she did not realize that the B Complex was not given and was not included in the cup of pills given to Resident #100. MA #1 stated that she must have skipped over the B Complex in Resident #100's electronic Medication Administration Record (MAR) because it was at the very top.On 6/16/26 at 9:32 AM, a follow-up interview with MA #1 revealed she did not notice the order for the Sertraline 25 mg to give three tablets and she only gave Resident #100 one tablet. MA #1 stated she should have pulled three tablets of the Sertraline 25 mg when she administered Resident #100's medications.An interview with the Director of Nursing (DON) on 6/16/26 at 1:20 PM revealed MA #1 should have made sure that she was taking the time to go over the rights of medication administration. The DON stated that the usual process was to get out the medication cards and go through them one by one, comparing them to the MAR before pulling them and administering them to the resident.An interview with the Physician Assistant on 6/17/26 at 10:19 AM revealed the medications should be given as ordered.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on record review, observation and staff interviews, the facility failed to implement their infection control policies when Nurse Aide #2 failed to change gloves and perform hand hygiene during incontinence care on Resident #2. This deficiency occurred for 1 of 5 staff members reviewed for infection control practices (Nurse Aide #2).The findings included:A review of the facility's policy titled Hand Hygiene, implemented on 1/2/26 indicated: Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table.Under the Hand Hygiene Table, staff were required to use either soap and water or alcohol-based hand rub when performing the following tasks:After handling contaminated objectsBefore and after handling clean or soiled dressings or linensAfter handling items potentially contaminated with blood, body fluids, secretions, or excretionsWhen, during resident care, moving from a contaminated body site to a clean body siteAfter assistance with personal body functions (e.g. elimination, hair grooming, smoking)An observation of incontinence care by Nurse Aide (NA) #2 on Resident #2 was made on 6/15/26 on 1:03 PM. While Resident #2 was turned towards his left side, NA #2 was observed cleaning stool off Resident #2's buttocks with wet washcloths. NA #2 was wearing gloves to both hands and a gown. NA #2 used at least three washcloths to wipe the stool off Resident #2's buttocks. While Resident #2 was turned to his left side, NA #2 started walking towards the door. Without removing her gloves, NA #2 opened the door and reached into the linen cart which was positioned right in front of Resident #2's door. NA #2 obtained a clean drawsheet from the linen cart and placed it under Resident #2's buttocks while removing the old drawsheet underneath his buttocks. NA #2 then assisted Resident #2 in rolling onto his back and proceeded to apply a new pull-up to Resident #2. She replaced Resident #2's covers and re-adjusted his bed. NA #2 placed the dirty washcloths in a plastic bag. She removed her gown and gloves from both hands and placed the trash in a separate bag. She discarded the trash and soiled washcloths and then used hand sanitizer to both hands.An interview with NA #2 on 6/15/26 at 1:14 PM revealed she did not remove her gloves after cleaning off the stool from Resident #2's buttocks, but she should have. NA #2 stated that she got nervous about being observed while she provided incontinence care to Resident #2, and forgot to change her gloves and perform hand hygiene before touching anything else in or outside the room.An interview with the Infection Preventionist on 6/16/26 at 3:06 PM revealed when the nurse aides were doing perineal care and cleaning feces, they should remove dirty gloves, sanitize or wash their hands and put on clean gloves before continuing care.An interview with the Director of Nursing (DON) on 6/16/26 at 1:20 PM revealed NA #2 should have removed her gloves, washed her hands and then get the supplies she needed or if she couldn't leave the bedside, right the call light if she needed something outside the room.