

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/04/2023
NAME OF PROVIDER OR SUPPLIER CREEKVIEW FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3524 DICKEY MILL ROAD MEBANE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 04/05/23.	C 000		
C 086	10A NCAC 13G .0315(b)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed is to have the following: This rule apply to new and existing homes. (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 6 residents (#1) was provided with clean top and bottom sheets for his bed. The findings are: Observation of Resident #1's room on 04/04/23 at 8:45am revealed: -Resident #1 had a bariatric bed (a larger-sized bed used to comfortably accommodate a heavy person).	C 086		

Division of Health Service Regulation

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

TITLE

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/04/2023
NAME OF PROVIDER OR SUPPLIER CREEKVIEW FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3524 DICKEY MILL ROAD MEBANE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 086	Continued From page 1 -Resident #1 was laying on the bed. -There were two blankets and a pillow on the bed. -There were no sheets on the bed. -Resident #1 was laying directly on the mattress. Interview with Resident #1 on 04/04/23 at 11:05am revealed: -He got his bigger bed and mattress a month or two ago. -Sometimes he used a flat/top sheet on top of his mattress so he was not laying directly on the mattress, but he did not know where the top sheet was. -He did not mind laying on the mattress because the material was not uncomfortable. -Staff wiped his bed down a couple of times per week since he did not have a sheet to change. Interview with the Supervisor-In-Charge (SIC) on 04/04/23 at 11:15am revealed: -Resident #1 did not have sheets on his bed because there were no sheets that fit his larger sized mattress. -She wiped down Resident #1's bed with cleaning spray twice per week. -Sometimes Resident #1 laid on a top sheet on top of his mattress, but she did not know where Resident #1's top sheet was. -Resident #1 had not complained to her about his bed not having sheets. Telephone interview with the Administrator on 04/04/23 at 1:15pm revealed: -She was not aware that Resident #1 had not been using sheets on his bed. -Resident #1 had a bariatric bed so it was a large sized mattress that regular sheets did not fit on. -Resident #1 had his bariatric bed for around 6 or 7 months. -When she ordered the bed and mattress last	C 086		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/04/2023
NAME OF PROVIDER OR SUPPLIER CREEKVIEW FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3524 DICKEY MILL ROAD MEBANE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 086	Continued From page 2 year, she had also ordered special sheets that would fit the bed. -The special ordered sheets were supposed to be delivered at the same time as the bed, but she had not asked for confirmation that the sheets had been delivered. -She did not know where the sheets were. -Staff had not notified her that Resident #1 did not have sheets that fit his bed.	C 086		
C 265	10A NCAC 13G .0904(c)(2) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service (c) Menus in Family Care Homes: (2) Menus shall be maintained in the kitchen and identified as to the current menu day for guidance of food service staff. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure menus were maintained in the kitchen with a current weekly menu available for guidance of food service staff. The findings are: Observation of the facility's kitchen on 04/04/23 at 9:00am revealed there was no weekly menu available for staff to reference while preparing meals.	C 265		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/04/2023
NAME OF PROVIDER OR SUPPLIER CREEKVIEW FAMILY CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3524 DICKEY MILL ROAD MEBANE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 265	Continued From page 3 Observation of the lunch meal on 04/04/23 at 11:45am revealed: -There were 5 residents present for the meal. -Each resident was served a chicken breast with barbecue sauce on top, half of a baked potato, a scoop of peas, a piece of cornbread, and a bowl of pineapple chunks. -Each resident was served water in a tall cup, and 8 ounces of milk. Interview with the Supervisor-In-Charge on 04/04/23 at 10:50am revealed: -All the residents in the facility were ordered a regular diet and received the same meals. -She was not aware of a diet book or a weekly/monthly meal menu and had not seen one in the 5-6 years she had worked at the facility. -She made up her own menu and gave the grocery list to the Administrator at the beginning of each month. -She made meals for the day based on the groceries available in the house. -They always had enough food to make a variety of meals. -She had never asked the Administrator for a menu because she did not know there was supposed to be one. -The Administrator had never told her what meals she should make for the residents. Interview with a resident on 04/04/23 at 11:00am revealed: -The SIC was a good cook and the meals she made for the residents were always balanced nutritionally. -The SIC provided the residents with a meat option, a vegetable, fruit and bread at each meal. -He did not have any concerns about the food provided to him by the facility.	C 265		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL001140	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 04/04/2023
NAME OF PROVIDER OR SUPPLIER CREEKVIEW FAMILY CARE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3524 DICKEY MILL ROAD MEBANE, NC 27302		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
C 265	Continued From page 4 -He did not know what the SIC was going to prepare for each meal prior to it being served. Telephone interview with the Administrator on 04/04/23 at 1:15pm revealed: -The facility had a menu book somewhere in the kitchen. -The SIC prepared a grocery list for her every month and she did the grocery shopping. -She thought the SIC was preparing the grocery list based on the menu provided. -Last year she had purchased an updated menu set for the facility from the same dietitian who had provided their previous menus. -She had seen the menu book on the table in the kitchen so the SIC should know where the book was. -All the residents at the facility were ordered a regular diet. -She had told the staff about the new menus last year when she brought them to the facility and asked the SIC to read through it and ask questions if she had any. -She was not aware the SIC was not preparing meals based on the menu.	C 265			