Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	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 and follow up survey on 09/25/24.	{C 000}		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Health Service Regulation for review of any possible changes that may be required to	C 007	The two residents were moved to my Assisted Living Facility (Burlington Care Center) I had been under the understanding that residents could be verbally prompted by the staff. Both of these residents were ambulatory but did need prompting. Staff will be provided training for evacuation process and fire drills. We are currently conducting weekly fire drills. Staff are being trained on documenting response time. Facility will ensure to admit residents whose evacuation capabilities match the capabilities listed on the facility's license. 10/01/2024	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lawanda [illegible] TITLE: OWNER (X6) DATE: 10/9/2024

Reviewed and acknowledged 10/11/24 kc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	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 007	Continued From page 1 the building. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 2 of 6 sampled residents who did not exit the facility during a fire drill. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Observation of the facility on 09/25/24 at 8:30am revealed six residents resided in the facility. Review of the facility's fire rehearsal schedule revealed: -On 06/09/24 at 10:00am, residents and one staff member participated in the fire drill; the response time was not documented. -On 07/10/24 at 3:00pm, residents and one staff member participated in the fire drill; the response time was 5 minutes. On 08/10/24 at 3:30pm, residents and one staff member participated in the fire drill; the response time was 6 minutes. On 09/10/24 (time of drill not documented), residents and one staff member participated in the fire drill; the response time was 5 minutes.	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	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 007	Continued From page 2 Observation of the facility on 09/25/24 at 1:45pm revealed: -Four residents were inside the facility. -One resident was on a leave of absence (LOA). -One resident was lying on his bed. -One resident was standing at the dining room table. -One resident was on the couch watching television. -The fire alarm sounded for 45 seconds. -Two of the four residents inside of the facility did not exit. Interview with the Administrator on 09/25/24 at 2:15pm revealed: -The two residents that did not exit the facility had to be prompted to exit. -She did not realize staff could not prompt the residents to exit during a rehearsal fire drill. -All of the residents were ambulatory. -She had not notified the Department of Health Service Regulation (DHSR) or anyone with the construction section because she did not know she needed to. Refer to Tag C0022 10 NCAC 13G .0302(b) Design and Construction.	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	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 022	Continued From page 3 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 2 of 6 sampled residents who did not respond to a fire alarm (#1, #2). The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for 6 ambulatory residents. Review of the facility's fire rehearsal schedule revealed: -On 06/09/24 at 10:00am, residents and one staff member participated in the fire drill; the response time was not documented. -On 07/10/24 at 3:00pm, residents and one staff member participated in the fire drill; the response time was 5 minutes. On 08/10/24 at 3:30pm, residents and one staff member participated in the fire drill; the response time was 6 minutes. On 09/10/24 (time of drill not documented), residents and one staff member participated in the fire drill; the response time was 5 minutes. Observation of the facility on 09/25/24 between 8:15am and 3:30pm revealed: -Six residents resided in the facility. -One of the residents assisted another resident to the breakfast table.	C 022	Both residents were relocated to my Assisted Living Facility (Burlington Care Center). Staff will be provided training for fire evacuation, fire drills and documenting response time to fire alam sounding off. All residents before being admitted to facility will be evaluated to verify competency of understanding of exiting the building during fire evacuations and what it means when siren sounds. The facility will ensure to admit residents whose evacuation capabilities match the capabilities listed on facility's license. This will be monitored by L.Ray on a weekly bases.	10/25/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	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 022	Continued From page 4 -The Medication Aide (MA) assisted one of the residents to the breakfast table. -All six residents were ambulatory. Observation of the facility on 09/25/24 at 1:45pm revealed: -Four residents were inside the facility. -One resident was on a leave of absence (LOA). -One resident was lying on his bed. -One resident was standing at the dining room table. -One resident was on the couch watching television. -One resident was outside on the porch. -The fire alarm sounded for 45 seconds. -Two of the four residents inside of the facility did not exit. Interview with the MA on 09/25/24 at 2:00pm revealed: -She conducted fire drills monthly. -She did not conduct fire drills on third shift. -She did not sound the alarm for the drills, she just yelled out "fire". -She had to tell two residents there was a drill and to go outside. -She did not know she could not help the residents get out during the fire drills. Interview with the Administrator on 09/25/24 At 2:15pm revealed: -Two residents in the facility had dementia and had to be told to go outside. -They worked with the residents on fire drills, but the two residents did not remember and had to be told each time. -She did not realize the staff could not prompt and assist the residents during the fire drills. 1. Review of Resident #1's current FL-2 dated	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	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 022	Continued From page 5 11/10/23 revealed: -Diagnoses included cerebrovascular accident and dementia. -The resident was intermittently disoriented. -The resident required personal care assistance with bathing and dressing. Review of Resident #1's Resident Register revealed an admission date of 02/24/20. Review of Resident #1's assessment and care plan dated 11/10/23 revealed: -The assessment was not complete. -He required limited assistance with bathing, dressing, and grooming. Observations of the facility on 09/25/24 at various times between 8:15am and 3:30pm revealed Resident #1 was able to ambulate independently from his room to the dining room and back without physical assistance but needed verbal cues for direction. Observation of the facility on 09/25/24 at 1:45pm revealed: -An audible fire alarm could be heard throughout the facility. -Resident #1 was in his room lying on his bed. -Resident #1 did not exit his room. Interview with the MA on 09/25/24 at 2:00pm revealed Resident #1's memory was not good and he had to be told to go outside during a fire drill. Interview with the Administrator on 09/25/24 at 2:15pm revealed: -Resident #1 had dementia. -Resident #1 did not know what the fire drill meant and needed assistance to exit the facility.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	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 022	Continued From page 6 Interview with Resident #1 on 09/25/24 at 1:50pm revealed: -He heard the alarm sound. -He did not know that it was a fire alarm, and he should exit the facility. -He did not know what the alarm was for. 2. Review of Resident #2's current FL-2 dated 03/22/24 revealed: -Diagnoses included hypertension and paranoid schizophrenia. -The resident was intermittently disoriented. -The resident required personal care assistance with bathing and dressing. Review of Resident #2's Resident Register revealed an admission date of 04/22/20. Observation of the facility on 09/25/24 at various times between 8:15am and 3:00pm revealed Resident #1 was able to ambulate independently but required verbal cues from staff for direction. Observation of the facility on 09/25/24 at 1:45pm revealed: -An audible fire alarm could be heard throughout the facility. -Resident #2 was sitting at the dining room table. -Resident #2 got up from the chair and stood behind it. -Resident #2 did not exit the facility. Interview with the MA on 09/25/24 at 2:00pm revealed Resident #1's memory was not good, and he had to be told to go outside druing a fire drill. Interview with the Administrator on 09/25/24 at 2:15pm revealed:	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001140	A. BUILDING: _____ B. WING _____	R 09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CREEKVIEW FAMILY CARE HOME	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 022	Continued From page 7 -Resident #2 had memory loss but there was not a diagnosis of dementia in his record. -Resident #2 recently lost a family member and could not remember that; he kept asking about them. -She asked Resident #2 during the fire alarm if he heard the alarm, and he said he did but he could not express what to do. Interview with Resident #2 on 09/25/24 at 2:45pm revealed: -He did not recall hearing the fire alarm. -He was unable to state the date or year. The facility failed to ensure the facility was equipped and maintained in accordance with the facility's licensed capacity to allow 2 of 6 residents living in the facility, who required verbal prompting when they responded to a fire drill; two of the residents were intermittently disoriented (#1, #2), one resident had a diagnosis of dementia (#1). The two residents were unable to evacuate the facilitiy without prompting during an emergency, such as a fire, and is detrimental to the health, safety, and well-being of the residents and constitutes a Type B Violation. The facilitiy provided an acceptable plan of protection in accordance with G.S. 131D-34 on 09/25/24. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 9, 2024.	C 022		