STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562	A. BUILDING _____ B. WING _____	03/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

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F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and	F 272		3/24/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/24/2017

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F 272	Continued From page 1 non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on an observation, resident and staff interviews and medical record review, the facility failed to complete a comprehensive assessment for section C (cognitive patterns), section D (mood and behavior patterns), and section J (health conditions related to pain) for an annual Minimum Data Set assessment for 2 of 18 sampled residents (Residents #16 and #120). The findings included: 1a. Resident #16 was admitted to the facility on 11/23/15. Diagnoses included cognitive communication deficit, chronic pain, pain in left hip, pain in right/left shoulders, osteoarthritis, end stage renal disease, chronic gout due to renal impairment, major depressive disorder, and anxiety disorder. Medical record review revealed Resident #16 was being followed by psychiatric services for memory loss, depression, anxiety and chronic pain and had a physician's order for Voltaren gel to be used, as needed for pain. Review of an annual Minimum Data Set (MDS) assessment dated 11/30/16 revealed sections C (cognitive patterns), D (mood and behavior), and J (health conditions related to pain) was not	F 272	Clear Creek Nursing and Rehabilitation Center acknowledges the receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Clear Creek and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceedings. F272 On 2/27/17, resident #120 was already discharged from the facility. To accomplish corrective action for those found to be affected by the alleged deficient practice, the last assessment	

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F 272	Continued From page 2 assessed. The annual MDS was signed on 12/19/16 as completed. Resident #16 was observed on 02/28/17 at 10:39 AM seated in a wheel chair in her room. Resident #16 verbalized complaints of foot pain and stated that she had just received her morning medications and wanted to go to bed and elevate her feet. Resident #16 turned on her call light, staff responded to assist Resident #16 to bed and elevated her feet per her request. 1b. Resident #120 was admitted to the facility on 09/05/16 and discharged on 10/22/16. Diagnoses included cognitive communication deficit and dementia with behaviors. Medical record review revealed nurse progress notes dated 09/06/16, 09/07/16, 09/08/16, 09/11/16 and 09/12/16 which documented that Resident #120 was confused, combative with wandering behaviors, and verbally abusive toward staff when redirected. Review of an annual MDS assessment dated 09/12/16 revealed sections C (cognitive patterns) and D (mood and behavior) were not assessed. The annual MDS was signed on 09/14/16 as completed. An interview with the social worker (SW) occurred on 02/28/17 at 5:03 PM and revealed that she was responsible for completing sections C and D of the comprehensive MDS, but that she was not the SW in the facility at the time either MDS assessment was completed. The SW stated that the MDS assessments for Residents #16 and #120 were not completed timely and that was the reason sections C and D were not assessed.	F 272	completed for resident #16 was reviewed. A Brief Interview for Mental Status (BIMS) Assessment and Mood Assessment was completed for resident #16 on 2/27/17 by the Social Worker and a progress note was entered into the resident□s clinical record indicating the resident□s clinical status, moods and behaviors and factors impacting care planning decisions. A pain assessment was completed for resident #16 on 3/2/17 by the Minimum Data Set Coordinator and a progress note was entered into the clinical record describing the resident□s clinical status and factors impacting care planning decisions related to pain by the Minimum Data Set Coordinator on 3/20/2017. Upon review, the assessment team has determined that all residents may be subject to being affected by the alleged deficient practice, thus a 100% audit of all current residents□ including resident #16 is necessary to identify those who may have potential to be affected. The 100% audit was completed on 3/22/17 by the Minimum Data Set Coordinator and reviewed for completeness by the Director of Nurses on 3/22/17. The audit included reviewing assessments for completeness in their entirety including sections C, D and J. These sections could not be altered retroactively when they were incomplete, thus progress notes were written in the resident□s clinical record by the appropriate clinical discipline for any identifies areas of concern or incompleteness describing the resident□s clinical status and factors impacting care planning decisions.	

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F 272	Continued From page 3 An interview with the MDS Coordinator and MDS nurse #2 occurred on 03/01/17 at 11:34 AM. During the interview, both stated that they began employment at the facility in January 2017 and did not complete the annual MDS in November 2016 for Resident #16 or in September 2016 for Resident #120. The interview revealed that the annual MDS assessments were not completed by the assessment reference dates and that was the reason sections C, D and J were not assessed. An interview with the Director of Nursing (DON) occurred on 03/01/17 at 2:27 PM. The DON stated that she started employment in the facility as the DON on 12/27/16 and that she was not the DON in the facility at the time these annual MDS assessments were completed. The DON further stated that she expected comprehensive assessments to be completed timely and that all areas should be assessed.	F 272	New measures and/or systemic changes to assure that the alleged deficient practice does not recur include Comprehensive re-education of the Interdisciplinary Care Planning Team was conducted by the Facility Nurse Consultant on 3/21/17 utilizing the RAI manual with specific focus on completion of all items on the MDS Assessment, especially sections C j, D and J. To monitor the facility□s performance and assure that solutions are sustained, a program of monitoring will be overseen by the facility□s Quality Assurance and Performance Improvement Committee. The Administrator and/or Director of Nurses will audit 10% of all comprehensive assessments weekly for 4 weeks, and then monthly for 3 months to assure accuracy and completeness of the said assessments. The results of these audit tools will be reported to the Quality Assurance and Performance Improvement Committee meeting at its monthly meeting for four months, and a decision made on the continuing monitoring made by the committee at the end of said 4 months. The corrective action will be implemented by 3/24/2017.	
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:	F 280		3/24/17

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F 280	Continued From page 4 (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be-	F 280		

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F 280	Continued From page 5 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to invited 3 of 15 sampled residents to participate in care plan meetings (Resident #75, Resident #73, Resident #68).	F 280	F280 To accomplish corrective action for those residents found to be affected by the alleged deficient practice, care plan meetings were offered to residents #75, #73 and #68 and/or the resident	

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F 280	Continued From page 6 The findings included: 1a. Resident #75 was admitted to the facility on 11/01/15 with cumulative diagnosis which included hypertension, heart failure, depression and dysphagia. An interview was conducted on 02/26/17 at 5:06 PM with Resident #75. Resident #75 revealed he had not had a care plan meeting in a couple of months. A review of the medical record revealed a social services note dated 05/11/16, revealed and read in part, a quarterly care plan notice was sent to the responsible party (RP) on 04/06/16 and the RP had not responded to schedule a meeting at this time. 1b. Resident #73 was admitted to the facility on 03/18/14 with cumulative diagnosis which included depressive disorder, and hyperlipidemia. An interview was conducted on 02/26/17 at 7:07 PM with Resident #73. Resident #73 revealed she had not had a care plan meeting since admission. Resident #73 stated she would like to be informed of her medical care. A review of the medical record on 05/11/16 revealed quarterly care plan notice sent out on 04/06/16, RP has not scheduled a meeting at this time. 1c. Resident #68 was admitted to the facility on 10/13/16 with cumulative diagnosis which included heart failure, hypertension, depression and history of falls.	F 280	responsible party/agent. A meeting was held for resident #75 on 3/20/2017; for resident #73 on 3/21/2017 and for resident #68 on 3/21/2017. The assessment team has determined that due to the nature of the alleged deficient practice, all residents may have the potential to be affected, 100% of all residents and/or responsible parties/agents are invited to attend care plan meetings by the social worker or her designee. All care plan meetings will be scheduled within 90 days from the effective date of the corrective action and will continue to be scheduled quarterly and/or with a significant change in status with the resident and/or resident□s responsible party being invited. To prevent the alleged deficient practice from recurring, comprehensive re-education was conducted on 3/21/2017 by the Facility Nurse Consultant for the entire Interdisciplinary Care Plan Team using the federal regulations regarding care planning conferences as found in American Health Care Association□s publishing of The Long Term Care Survey. To monitor for the prevention of recurrence and to incorporate into the facility□s Quality Assurance and Performance Improvement system, The Administrator and/or Director of Nurses will audit the care plan calendar weekly for 12 weeks using the care plan audit tool created by the facility to assure care plan meetings are completed. The results of the care plan audit tool will be compiled by the Administrator and/or Director of Nurses and presented to the Quality	

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F 280	Continued From page 7 Interview conducted on 02/26/17 at 7:34 PM with Resident #68 revealed she had not received notification for a care plan meeting and would like to participate. An interview with the social worker (SW) occurred on 02/28/17 at 3:30 PM, and revealed Resident #68 had not received notification for a scheduled care plan meeting. During the interview, the SW revealed she started employment with the facility in January 2017. She stated she was responsible for scheduling care plan meetings. She stated she did not know why there was not a follow up with residents and families. The social worker further stated, residents and families should be invited to participate in care plan meetings quarterly. She reported that quarterly care plan meetings were going to be schedule every Wednesday starting 03/08/2017. An interview with the Director of Nursing (DON) occurred on 02/28/17 at 5:03 PM. During the interview, she stated she expected care plan meetings to be scheduled quarterly. The DON further stated, residents and families were going to be invited to participate in care plans starting 03/08/2017.	F 280	Assurance and Performance Improvement Committee monthly for 3 months. A determination will be made by the committee at that time regarding further monitoring.	
F 500 SS=D	483.70(g)(1)(2)(i)(ii) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT (g) Use of outside resources. (1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an	F 500		3/24/17

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F 500	Continued From page 8 arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. (2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to obtain a written agreement for services provided by an outside provider for 2 of 3 residents(Resident #110, Resident #153) receiving dialysis services and the residents received dialysis without a contract in place. Findings included: A recertification survey was conducted 02/26/2017-03/01/2017. On 2/27/2017 the facility's Nurse Consultant provided a list of 3 residents receiving outside hemodialysis services. On 02/27/2017 a dialysis contract was provided by the Administrator for dialysis services provided to the residents. 0n 02/27/2017 review of Resident #110's chart	F 500	F500 To accomplish corrective action for the resident (#110) found to have been affected by the alleged deficient practice, a contract arrangement that meets the requirements of section 1861 of the act was entered into between the facility and the professional dialysis center which provides said service to the resident (#110) on March 1, 2017. To accomplish corrective action for those other residents who may have been affected by the alleged deficient practice, a comprehensive listing of all providers who work within the facility and fall under the governance of this rule was developed. This list was reviewed for inclusiveness by the Quality Assurance and Performance Improvement Committee and deemed to be complete on March 20, 2017. The Quality Assurance Performance Improvement	

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F 500	Continued From page 9 revealed she was receiving dialysis services provided by a different dialysis service provider than listed on the dialysis contract. On 02/27/2017 at 5:45 PM an interview with the Administrator revealed he did not have a copy of the contract for the dialysis center that provided service to Resident #110. He stated he would call and get a copy of the contract in the morning on 02/28/2017. On 02/28/2017 at 1:45 PM an interview with the Administrator revealed that there was no contract with the dialysis center that provided Resident #110 dialysis. He was unaware there was no contract since things were running smoothly and residents were receiving their dialysis. He stated they were in the process of getting a contract. He stated it was his expectation for all services that their residents receive that require a contract they have one in place. On 03/01/2017 at 02:15 PM an interview with the Director of Nursing (DON) revealed Resident #153 received dialysis at the center where the facility currently did not have a contract.	F 500	Committee appointed a designee to review the list and assure that contracts meeting the requirements of the rule were in place with all identified providers. This list was completed by the Quality Assurance Performance Improvement Committee on 3/23/2017 and deemed to be complete, indicating the facility□s compliance with the requirement. As a systemic change and to monitor compliance through the Quality process, the facility will bring its master contracts lists with any noted additions to the monthly meeting of the Quality Assurance and Performance Improvement Committee. The committee will review the list, assure compliance with the regulation, and note its review in the minutes of the meeting. All corrections will be accomplished by 3/24/2017.	