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 ______	C 05/31/2018

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 000	INITIAL COMMENTS 1. 483.10 (F580) at J. Immediate Jeopardy began on 05/11/18 when Resident #1 began to exhibit right side facial droop, slurred speech and drooling. Nurse #1 did not assess the resident's change in condition and therefore did not report the change in condition to her medical provider or responsible party. Immediate Jeopardy was removed on 05/31/18 at 5:53 PM when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of a D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place for reporting a resident's change in condition were effective. 2. 483.25 (F684) at J Immediate jeopardy began on 05/11/18 when Resident #1 began to exhibit signs and symptoms of a stroke that included slurred speech, right side facial droop, and drooling. Nurse #1 was notified by various staff and visitors that Resident #1 was exhibiting slurred speech, right sided facial droop, and drooling and did not assess Resident #1. Immediate jeopardy was removed on 05/31/18 at 5:53 PM when the facility provided and implemented an acceptable allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place for assessing a	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed | TITLE | (X6) DATE 06/22/2018

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.

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F 000	Continued From page 1 resident with a change in condition are effective. A revisit was conducted from 05/29/18 to 05/31/18 and the facility remains out of compliance. Event ID# QMN712. An extended survey was conducted as part of the facility's follow-up and complaint investigation survey from 05/29/18 to 05/31/18. Event ID# HCFX11.	F 000		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the	F 580		6/29/18

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F 580	Continued From page 2 physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, visitors, family, Nurse Practitioner and Medical Doctor interviews the facility failed to notify a resident's responsible party and Medical Doctor that the resident began having facial droop, slurred speech and drooling which resulted in a stroke. The facility also failed to notify a resident's responsible party of an antibiotic which was ordered to treat a urinary tract infection (UTI) for 1 of 3 residents reviewed for change in condition (Resident #1). Immediate Jeopardy began on 05/11/18 when Resident #1 began to exhibit right side facial	F 580	Clear Creek Nursing and Rehab acknowledges 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 residents. The Plan of Correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehab response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any	

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droop, slurred speech and drooling. Nurse #1 did not assess the resident's change in condition and therefore did not report the change in condition to her medical provider or responsible party. Immediate Jeopardy was removed on 05/31/18 at 5:53 PM when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of a D (no actual harm with potential for more than minimal harm that is not Immediate Jeopardy) to complete education and ensure monitoring systems put into place for reporting a resident's change in condition were effective.

The findings included:

Resident #1 was readmitted to the facility on 09/18/14 with diagnoses which included hypertension and dementia.

Review of Resident #1's most recent comprehensive Minimum Data Set (MDS) assessment dated 02/23/18 revealed that she was cognitively impaired and required limited assistance with her activities of daily living (ADLs). The MDS further indicated that she had clear speech and was usually understood by others.

On 05/29/18 at 6:30 PM an interview was conducted with a Restorative Aide (RA) who stated that on 05/11/18 at approximately 1:00 PM she was weighing Resident #1 when she noticed she was not acting like herself. The RA stated Resident #1's speech was slurred and muffled so she pushed her to Nurse #1 and informed the Nurse of what she had observed of Resident #1 and the Nurse indicated she was aware of

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deficiency is accurate. Further, Clear Creek Nursing and Rehab 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 proceeding.

F580 Notification of Changes

1. The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited

On 5/30/18, Clear Creek Nursing and Rehabilitation Center was placed into Immediate Jeopardy at 5:00 PM for failing to provide Quality of Care. The process that led to the deficiency was determined to be the facility's failure to notify the family/physician/nurse practitioner of Resident #1's change of condition when the resident showed signs of facial drooping and drooling.

2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 5/10/18, the MDS nurse's Care Plan – General Note indicated Resident #1 was at baseline and did not indicate Resident #1 with facial drooping or other change in condition.

On 5/11/18 earlier in the day before 11 AM, Nurse #1 did observe Resident #1's change in clarity of ZC speech, but did not see any facial drooping or drooling,

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Resident #1's condition and the Nurse pushed Resident #1 towards her room.

An interview was conducted with Visitor #1 on 05/29/18 at 3:40 PM who stated she was a daily visitor to the facility and was familiar with how Resident #1 normally acted. Visitor #1 stated that on 05/11/18 at approximately 2:45 PM she noticed Resident #1 was rolling herself around in her wheelchair using her legs and flailing her arms in the air and hollering but nothing she said made sense. The Visitor stated Resident #1's mouth was drawn to one side (she could not remember which side) and she was drooling. Visitor #1 stated to Nurse #1 that she thought Resident #1 was having a stroke and Nurse #1 told Visitor #1 they were taking care of it.

On 05/29/18 at 4:10 PM an interview was conducted with Visitor #2 who stated she too was a daily visitor to the facility and knew the behaviors of Resident #1. The Visitor stated she arrived at the facility around 5:00 PM on 05/11/18 and observed Resident #1 in her wheelchair making all kinds of noises but her speech was not making sense. Visitor #2 further stated that Resident #1 was slurring her speech, had facial droop and was drooling. The Visitor stated she looked around and could not find a staff member to report her concern to so she went toward the front lobby but on her way to the lobby she saw two therapy staff in the therapy gym and went to report her concerns to them. Visitor #2 stated after she told them of her observation of the slurred speech, drooling and facial droop that Resident #1 was having, they immediately went to check on her themselves.

An interview was conducted with PT #1 and PT

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and then called the nurse practitioner to verify the nurse practitioner would be at the facility on 5/11/18. Nurse #1 is a licensed practical nurse (LPN) and it is not in the scope of practice for an LPN to assess.

On 5/11/18 at approximately 11:46 AM, the physician extender nurse practitioner (NP) note indicated Resident #1 was seen by the NP. The NP note indicated "Patient seen for acute care. Meds, labs, notes reviewed…alert, confused…UA reviewed, + for leukocytes, positive for nitrates…patient refuses PO medications, give Rocephin 1 gram IM q24h x 3 doses, give with lidocaine." The NP note did not indicate Resident #1 with right facial drooping.
On 5/11/18 at approximately 1:00 PM, the restorative aide noticed Resident #1's speech was not clear while weighing her and took the resident to Nurse #1.

On 5/11/18, at approximately 1:00 PM, the restorative aide witnessed Nurse #1 looking at Resident #1 and watched Nurse #1 transport Resident #1 to the nurse station for observation. Nurse #1 did not document an assessment in the electronic health record. Not recognizing there was a change of condition, LPN #1 did not notify a registered nurse (RN), nurse practitioner (NP), or physician (MD) to re-assess Resident #1 in the afternoon as the day progressed on 5/11/18.

On 5/11/18 at approximately 2:45 PM, a different resident's family member

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F 580	Continued From page 5 #2 on 05/29/18 at 5:30 PM. PT #1 stated that on 05/11/18 at approximately 5:30 PM Visitor #2 came into the therapy gym and reported to them that Resident #1 had slurred speech, facial droop and was drooling. Both PT #1 and PT #2 went to check on Resident #1 and found her to have the same symptoms that Visitor #2 reported to them. PT #1 and PT #2 went to report their observation to Nurse #1 who stated, Resident #1 was seen by the Nurse Practitioner (NP) earlier that day and was being treated for a UTI. On 05/29/18 at 4:34 PM an interview was conducted with the NP who stated that on the morning of 05/11/18 she was asked by Nurse #1 to evaluate Resident #1 because something was wrong with her. The NP stated she went to evaluate Resident #1 and she was not her normal "spry" self. Then she reviewed her urinalysis (analysis of urine) which indicated Resident #1 had a UTI so she ordered an antibiotic for her. The NP stated that Resident #1 did not show any signs or symptoms of a stroke for example slurred speech, facial droop or drooling or she would have sent her to the emergency room. The NP further stated she was in the facility until around 5:00 PM and at no time was she alerted to any other changes in Resident #1. On 05/29/18 at 5:20 PM an interview was conducted with Nurse #1 who indicated that throughout the day staff and visitors informed her of Resident #1's slurred speech, facial droop, and drooling but she felt they were the effects of the UTI that the NP diagnosed her with earlier that day. Nurse #1 admitted she did not call Resident #1's responsible party (RP) nor did she notify the NP/MD of Resident #1's right side facial droop, slurred speech or drooling.	F 580	reported that she attempted to approach Nurse #1 regarding Resident #1. Nurse #1 stated she could not recall this specific visitor interaction. On 5/11/18 after 5:00 PM, the therapist reported to Nurse #1 that Resident #1 was exhibiting slouched posture, drooling and slurred speech. Nurse #1 stated the NP assessed the resident in the morning and Resident #1 was on antibiotic therapy for a urinary tract infection. On 5/11/18 at approximately 6:00 PM, Nurse #1 administered an antibiotic injection for Resident #1. At that time, Nurse #1 did not note observing facial drooping or drooling. On 5/11/18 at the 7 PM shift change, Nurse #1 reported to medication aide (MA) #1. Nurse #1 and MA #1 did not report to a registered nurse (RN) Resident #1’s change in condition (right facial drooping, drooling, and continued slurred speech) for assessment, failing to follow established policy. On 5/12/18 at approximately 10:08 AM, registered nurse (RN) #1 assessed Resident #1. The assessment revealed Resident #1 had a change in condition (right facial drooping). RN #1 contacted Resident #1’s physician/nurse practitioner provider. The provider gave an order to send Resident #1 to the emergency department (ED) for evaluation. RN #1 also contacted Resident #1’s resident representative (RR)/daughter. RN #1 sent Resident #1 to the ED as ordered by the provider. The RR met Resident #1 at	

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An interview was conducted with Nurse Aide #1 on 05/30/18 at 12:54 PM. NA #1 stated she took care of Resident #1 on 05/11/18 on first and second shifts. She stated that Resident #1 was not acting like herself, her speech was slurred and she was drooling from one side of her mouth. The NA stated she reported her observation to Nurse #1 and was told that Resident #1 had already been evaluated by the NP and was being treated for a UTI. NA #1 stated that she put Resident #1 in the bed per her usual routine and when she left her shift at 11:00 PM on 5/11/18 Resident #1 was resting in bed with her eyes closed.

An interview was conducted with NA #2 on 05/30/18 at 11:54 AM, she confirmed that she worked third shift on 05/11/18 and stated that Resident #1 rested in bed the entire night and she did not notice anything different with her. The NA stated she rendered incontinent care to Resident #1 at approximately 5:00 AM on 05/12/18 and during the interaction she did not notice any unusual behavior or anything out of the normal for Resident #1. She stated that if she had noticed anything abnormal with Resident #1, she would have notified the nurse.

An interview was conducted with Nurse #2 on 05/31/18 at 12:50 PM who confirmed he worked third shift on 05/11/18 and was responsible for Resident #1. The Nurse stated that during report he was notified that Resident #1 had not been acting like herself but had been evaluated by the NP and was started on an antibiotic for a UTI. Nurse #2 stated that the resident rested throughout the night and he never had to interact with her that night. He added that NA #2 did not

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the ED. The resident representative/daughter reported to ED physician that Resident #1 was at baseline on 5/10/18. The resident representative/daughter also reported noticing right facial drooping on the morning of 5/12/18.

On 5/12/18 through 5/16/18, the ED physician evaluation, including laboratory and radiology test results indicated no evidence that Resident #1 had a cerebrovascular (CVA), "Workup here so far has been normal except the fact that she has been hypertensive, was also started on antibiotics for her urinary tract infections yesterday." On 5/12/18, physician orders were given to discharge Resident #1 back to the facility with no medications ordered. The discharge diagnoses of CVA, DNR, dementia, hyperlipidemia, and hypertension are listed on the hospital discharge summary. Resolved diagnosis included acute cystitis without hematuria. On 5/16/18, Resident #1 returned to the facility with discharge instruction for hospice evaluation.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

On 5/30/18, the minimum data set (MDS) RN and wound nurse RN assessed each resident. The RN assessment of each resident included taking vital signs, pain, and mental status for change in condition.

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F 580	Continued From page 7 report any abnormal observations of Resident #1 that evening and it was a normal night for Resident #1. An interview was conducted with Nurse #3 on 05/31/18 at 1:01 PM who confirmed she worked first shift on 05/12/18 and was responsible for Resident #1. The Nurse stated that approximately 10:00 AM Resident #1's RP approached her and asked her to check the resident's vital signs because something wrong with her. Nurse #3 stated that she had not seen Resident #1 prior to the family asking her to check her vital signs but when she went to obtain Resident #1's vital signs she did not notice any drooling or facial droop. Nurse #3 stated she asked Resident #1 to smile and she did then she asked her to raise both arms in the air which she did as well. Nurse #3 stated that her assessment revealed no change in Resident #1 from her baseline but the RP requested for her to be sent to the Emergency Room (ER) for evaluation so she sent her out. An interview was conducted with Resident #1's RP on 05/29/18 at 2:17 PM who stated that she arrived at the facility on 05/12/18 at approximately 10:15 AM to take Resident #1 out for a few hours and was waiting on the staff to get her dressed. The RP stated Visitor #1 came in and informed her of what she had witnessed the day before with Resident #1. The RP stated that when Nurse #3 pushed Resident #1 into the dining area she saw her for the first time that day and noticed her mouth was drawn to the right side. The RP stated she asked Resident #1 if she was okay and she stated she was not okay. The RP stated she then asked Nurse #3 if Resident #1 was okay that she looked like she had a stroke and Nurse #3 told her she looked that way that morning. The RP	F 580	The purpose of the assessments was to protect Resident #1 and other residents in similar situations. The findings of the assessments: no current facility residents have a new/previously unidentified change in condition requiring additional assessment or physician/NP/resident representative notification. On 5/30/18, the director of nursing (DON) initiated a re-education with all nursing staff to include nursing assistants (NAs), MAs, LPNs, and RNs. The re-education covered the topic of “Notification.” “Notification of changes, Notification of MD/NP and RP. When alerted of a change in a resident, complete an assessment and document. Reporting changes include bruises of unknown origin…” On 5/30/18, the facility administrator and DON consulted with the regional vice president (RVP) and corporate RN facility consultant. The RVP and corporate consultant re-educated the administrator and DON. The re-education covered the topics of Quality of Care and the requirements for Notification of Changes. In addition, the RVP and corporate consultant reviewed with the administrator and DON topics of: 1) Change in Condition policy, 3) failure to assess for change of condition resulting from failure to follow established policy, and 4) the importance of addressing resident/family concerns related to Quality of Care.	

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F 580	Continued From page 8 stated she insisted Resident #1 be sent to the ER for evaluation and they did. The RP explained that she was not notified of Resident #1's change in condition, having a UTI or that she had been started on an antibiotic nor had she been informed of her having facial droop, slurred speech or drooling until the morning she was sent to the ER. An interview was conducted with the Director on Nursing (DON) on 05/30/18 at 3:30 PM who stated that on the morning of 05/12/18 she had arrived at the facility and was informed that Resident #1's RP was there and felt that she was having a stroke. The DON stated she immediately went to check on Resident #1 but initially could not tell if anything was wrong with her until Resident #1 tried to speak then she knew something was not right with Resident #1. The DON also stated she was not aware that Resident #1 started having facial droop and drooling after the NP evaluated her on the morning of 05/11/18. The DON added if Resident #1's symptoms were reported to the nursing staff then they should have been reported to her as well. On 05/30/18 at 12:10 PM an interview was conducted with the Medical Doctor (MD) who stated that if Resident #1 began to display facial droop, drooling and slurred speech on 05/11/18, that those were all classic signs of a stroke, and should have been reported to the NP who was in the building so the resident could be reevaluated immediately and sent to the emergency room. The MD continued to state that Resident #1 had returned to her baseline neurologically and physically and had done well while working with therapy. He added that when Resident #1	F 580	On 5/30/18, the corporate consultant initiated a 100% audit of the nurse progress notes from 5/1/18 through 5/30/18. The purpose of the audit was to identify any needed resident assessment for Resident #1 or other resident at risk of a change of condition that has not been assessed and addressed through physician/NP provider notification and RR notification. Any resident needing assessment will be assessed by a RN and notifications made to the care provider and RR. 6/21/18 the Facility RN consultant re-educated the IDT (Interdisciplinary Team) on the morning clinical meeting format, and follow up items process. The facility IDT (Interdisciplinary team) will review in morning clinical meeting the progress notes dated from previous to current meeting to determine potential changes of conditions in resident conditions to include notification of physician and or Physician Extender and Resident Representative. The review will include copies of physician orders, clinical alerts that include meal intake, skin alerts, incidents, care plan updates or revisions, and resident and or family concerns. The DON (Director of Nursing) will document any follow up items that require completion by end of day. The results of the daily IDT team meeting will be communicated to the Administrator. To maintain continued the results of the Follow up items and compliance will be submitted to the Facility's QA Committee	

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presented to the ER, her scan of her brain was abnormal and indicated a stroke but could not determine how old. The MD added that because we could not identify when the stroke occurred or how old it was along with Resident #1's advanced age she would not have qualified for the treatment of tissue plasminogen activator (TPA) (treatment for stroke).

Review of the Discharge Summary from the hospital dated 05/16/18 indicated Resident #1 had presented to the ER on 05/12/18 and the scan of her head revealed punctate age indeterminate lunar (stroke) in the right basal ganglia and right thalamus (parts of the brain). Her readmitting diagnosis to the facility included a stroke.

An observation was made of Resident #1 on 05/30/18 at 12:10 PM where she was sitting in her wheelchair in the common area. She was calm and no facial droop or drooling was noted.

An observation was made of Resident #1 on 05/31/18 8:00 AM where she was sitting at the breakfast table waiting to be served her meal. She was calm and pleasant and no drooling or facial droop was evident.

On 05/30/18 at 4:51 PM the administration was notified of Immediate Jeopardy. The facility provided the following credible allegation of removal on 05/31/18 at 4:15 PM:

1. The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited

On 5/30/18, Clear Creek Nursing and

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monthly for three months then quarterly for review and guidance.

If additional issues are noted those issues will be addressed immediately and corrective action taken

4. The title of the person responsible for implementing the acceptable plan of correction.
The administrator will be implementing and is responsible for implementing the acceptable plan of correction.

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Rehabilitation Center was placed into Immediate Jeopardy at 5:00 PM for failing to provide Quality of Care. The process that led to the deficiency was determined to be the facility's failure to notify the family/physician/nurse practitioner of Resident #1's change of condition when the resident showed signs of facial drooping and drooling.

2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 5/10/18, the MDS nurse's Care Plan - General Note indicated Resident #1 was at baseline and did not indicate Resident #1 with facial drooping or other change in condition.

On 5/11/18 earlier in the day before 11 AM, Nurse #1 did observe Resident #1's change in clarity of speech, but did not see any facial drooping or drooling, and then called the nurse practitioner to verify the nurse practitioner would be at the facility on 5/11/18. Nurse #1 is a licensed practical nurse (LPN) and it is not in the scope of practice for an LPN to assess.

On 5/11/18 at approximately 11:46 AM, the physician extender nurse practitioner (NP) note indicated Resident #1 was seen by the NP. The NP note indicated "Patient seen for acute care. Meds, labs, notes reviewed ...alert, confused ...UA reviewed, + for leukocytes, positive for nitrates ...patient refuses PO medications, give Rocephin 1 Gram IM q 24h x 3 doses, give with lidocaine." The NP note did not indicate Resident #1 with right facial drooping.

On 5/11/18 at approximately 1:00 PM, the restorative aide noticed Resident #1's speech

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F 580	Continued From page 11 was not clear while weighing her and took the resident to Nurse #1. On 5/11/18, at approximately 1:00 PM, the restorative aide witnessed Nurse #1 looking at Resident #1 and watched Nurse #1 transport Resident #1 to the nurse station for observation. Nurse #1 did not document an assessment in the electronic health record. Not recognizing there was a change of condition, LPN #1 did not notify a registered nurse (RN), nurse practitioner (NP), or physician (MD) to re-assess Resident #1 in the afternoon as the day progressed on 5/11/18. On 5/11/18 at approximately 2:45 PM, a different resident's family member reported that she attempted to approach Nurse #1 regarding Resident #1. Nurse #1 stated she could not recall this specific visitor interaction. On 5/11/18 after 5:00 PM, the therapist reported to Nurse #1 that Resident #1 was exhibiting slouched posture, drooling and slurred speech. Nurse #1 stated the NP assessed the resident in the morning and Resident #1 was on antibiotic therapy for a urinary tract infection. On 5/11/18 at approximately 6:00 PM, Nurse #1 administered an antibiotic injection for Resident #1. At that time, Nurse #1 did not note observing facial drooping or drooling. On 5/11/18 at the 7 PM shift change, Nurse #1 reported to medication aide (MA) #1. Nurse #1 and MA #1 did not report to a registered nurse (RN) Resident #1's change in condition (right facial drooping, drooling, and continued slurred speech) for assessment, failing to follow established policy.	F 580		

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On 5/12/18 at approximately 10:08 AM, registered nurse (RN) #1 assessed Resident #1. The assessment revealed Resident #1 had a change in condition (right facial drooping). RN #1 contacted Resident #1's physician/nurse practitioner provider. The provider gave an order to send Resident #1 to the emergency department (ED) for evaluation. RN #1 also contacted Resident #1's resident representative (RR)/daughter. RN #1 sent Resident #1 to the ED as ordered by the provider. The RR met Resident #1 at the ED. The resident representative/daughter reported to ED physician that Resident #1 was at baseline on 5/10/18. The resident representative/daughter also reported noticing right facial drooping on the morning of 5/12/18.

On 5/12/18 through 5/16/18, the ED physician evaluation, including laboratory and radiology test results indicated no evidence that Resident #1 had a cerebrovascular (CVA), "Workup here so far has been normal except the fact that she has been hypertensive, was also started on antibiotics for her urinary tract infections yesterday." On 5/12/18, physician orders were given to discharge Resident #1 back to the facility with no medications ordered. The discharge diagnoses of CVA, DNR, dementia, hyperlipidemia, and hypertension are listed on the hospital discharge summary. Resolved diagnosis included acute cystitis without hematuria. On 5/16/18, Resident #1 returned to the facility with discharge instruction for hospice evaluation.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in

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F 580	Continued From page 13 compliance with the regulatory requirements On 5/30/18, the minimum data set (MDS) RN and wound nurse RN assessed each resident. The RN assessment of each resident included taking vital signs, pain, and mental status for change in condition. The purpose of the assessments was to protect Resident #1 and other residents in similar situations. The findings of the assessments: no current facility residents have a new/previously unidentified change in condition requiring additional assessment or physician/NP/resident representative notification. On 5/30/18, the director of nursing (DON) initiated a re-education with all nursing staff to include nursing assistants (NAs), MAs, LPNs, and RNs. The re-education covered the topic of "Notification." "Notification of changes, Notification of MD/NP and RP. When alerted of a change in a resident, complete an assessment and document. Reporting changes include bruises of unknown origin ..." On 5/30/18, the facility administrator and DON consulted with the regional vice president (RVP) and corporate RN facility consultant. The RVP and corporate consultant re-educated the administrator and DON. The re-education covered the topics of Quality of Care and the requirements for Notification of Changes. In addition, the RVP and corporate consultant reviewed with the administrator and DON topics of: 1) Change in Condition policy, 3) failure to assess for change of condition resulting from failure to follow established policy, and 4) the importance of addressing resident/family	F 580		

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F 580	Continued From page 14 concerns related to Quality of Care. On 5/30/18, the corporate consultant initiated a 100% audit of the nurse progress notes from 5/1/18 through 5/30/18. The purpose of the audit was to identify any needed resident assessment for Resident #1 or other resident at risk of a change of condition that has not been assessed and addressed through physician/NP provider notification and RR notification. Any resident needing assessment will be assessed by a RN and notifications made to the care provider and RR. 4. The title of the person responsible for implementing the acceptable plan of correction. The administrator will be implementing and is responsible for implementing the acceptable plan of correction. Immediate Jeopardy was removed on 05/31/18 at 5:53 PM when interviews with nursing staff revealed they had been educated on when to report a resident's change in condition as well as who to report the change in condition to.	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		6/29/18

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F 684	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff, visitor, family, Nurse Practitioner, and Medical Doctor interviews the facility failed to assess a resident that exhibited signs and symptoms of cerebrovascular accident (stroke). This resulted in a delayed hospital evaluation and possible treatment for a stroke 1 of 3 residents sampled for quality of care (Resident #1). Immediate jeopardy began on 05/11/18 when Resident #1 began to exhibit signs and symptoms of a stroke that included slurred speech, right side facial droop, and drooling. Nurse #1 was notified by various staff and visitors that Resident #1 was exhibiting slurred speech, right sided facial droop, and drooling and did not assess Resident #1. Immediate jeopardy was removed on 05/31/18 at 5:53 PM when the facility provided and implemented an acceptable allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to complete education and ensure monitoring systems put into place for assessing a resident with a change in condition are effective. The findings included: Resident #1 was admitted to the facility on 09/18/14 with diagnoses that included dementia and hypertension. Review of the most recent comprehensive Minimum Data Set (MDS) dated 02/23/18 revealed that Resident #1 was cognitively impaired and required limited assistance with activities of daily living. The MDS further revealed	F 684	F684 Quality of Care 1. The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited On 5/30/18, Clear Creek Nursing and Rehabilitation Center was placed into Immediate Jeopardy at 5:00 PM for failing to provide quality of care. The process that lead to the deficiency was determined to be the facility's failure to assess for change of condition when the licensed practical nurse (LPN, Nurse #1) did not report to a registered nurse (RN) for re-assessment of Resident #1 after receiving reports of the resident showing signs of facial drooping and drooling. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/10/18, the minimum data set (MDS) nurse's care plan – General Note indicated Resident #1 was at baseline and did not indicate Resident #1 with facial drooping or other change in condition. On 5/11/18 earlier in the day before 11 AM, Nurse #1 did observe Resident #1's change in clarity of speech, but did not see any facial drooping or drooling, and then called the nurse practitioner to verify the nurse practitioner would be at the facility on 5/11/18. Nurse #1 is a LPN and	

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that Resident #1 had clear speech and was usually understood by others.

Review of a Nurse Practitioner (NP) progress noted dated 05/11/18 at 11:46 AM read, Resident #1 was seen for acute care. Medications, laboratory values, and notes were reviewed. Staff noted that Resident #1 has had change in mental status and was having difficulty speaking. Resident #1 was very confused and was not interacting with me when assessed. Her assessment revealed Resident #1 was calm and pleasant but confused. Review of a urinalysis (analysis of the urine) revealed it was positive for leukocytes (a cell that could indicate a urinary tract infection) and nitrites (a cell that could indicate a urinary tract infection). The assessment and plan read, Urinary tract infection (UTI): Resident #1 refuses to take medications by mouth. Give Rocephin (antibiotic) 1 gram (gm) intramuscular (IM) every day for 3 days.

An interview was conducted with the NP on 05/29/18 at 4:34 PM. The NP stated that on 05/11/18 Nurse #1 stated "something was wrong" with Resident #1. The NP stated she went to see Resident #1 and evaluated her and reviewed her laboratory values. The laboratory values indicated that she had a UTI and she was not her usual "spry" or "jovial" self. The NP stated at the time she evaluated Resident #1 she had no slurred speech or any other signs that indicated she may be having a CVA or stroke or she would have sent Resident #1 to the hospital. She indicated that her assessment and review of her medical record indicated that Resident #1 had a UTI and she was placed on Rocephin for 3 days. The NP also confirmed that she was not alerted to any other changes that transpired with Resident #1 that

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it is not in the scope of practice for an LPN to assess.

On 5/11/18 at approximately 11:46 AM, the physician extender nurse practitioner (NP) note indicated Resident #1 was seen by the NP. The NP note indicated "Patient seen for acute care. Meds, labs, notes reviewed…alert, confused…UA reviewed, + for leukocytes, positive for nitrates…patient refuses PO medications, give Rocephin 1 gram IM q24h x 3 doses, give with lidocaine." The NP note did not indicate Resident #1 with right facial drooping.

On 5/11/18 at approximately 1:00 PM, the restorative aide noticed Resident #1's speech was not clear while weighing her and took the resident to Nurse #1.

On 5/11/18, at approximately 1:00 PM, the restorative aide witnessed Nurse #1 looking at Resident #1 and watched Nurse #1 transport Resident #1 to the nurse station for observation. Nurse #1 did not document her observation of Resident #1 in the electronic health record. Not recognizing there was a change of condition, LPN #1 did not notify a registered nurse (RN), NP, or physician (MD) to re-assess Resident #1 in the afternoon as the day progressed on 5/11/18.

On 5/11/18 at approximately 2:45 PM, a different resident's family member reported that she attempted to approach Nurse #1 regarding Resident #1. Nurse

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day.

An interview was conducted with the Restorative Aide (RA) on 05/29/18 at 6:30 PM. The RA stated that on 05/11/18 she was doing weights in the facility. While weighing Resident #1 at approximately 1:00 PM the RA noted that Resident #1 was not acting like herself, she was agitated her speech was slurred and muffled. The RA indicated that she pushed Resident #1 in her wheelchair to Nurse #1 and informed her that her speech was slurred and she was not acting like herself. She stated Nurse #1 indicated that she was aware of Resident #1's condition and pushed Resident #1 back towards her room.

An interview was conducted with Visitor #1 on 05/29/18 at 3:40 PM. Visitor #1 indicated she arrived at the facility on 05/11/18 at approximately 2:45 PM and noticed Resident #1 rolling around the halls hollering but nothing she said made any sense. She further indicated that Resident #1 was flailing her arms around in the air and was drooling and her mouth was drawn to one side but she could not recall which side. Visitor #1 stated she saw Nurse #1 and stated to her "I think Resident #1 is having a stroke." Visitor #1 stated that Nurse #1 replied "we are taking care of it" and that was it. Visitor #1 stated that later in the day she told Visitor #2 that something was wrong with Resident #1. Visitor #1 stated she did not see Nurse #1 go and check on Resident #1 during her time in the facility.

An interview was conducted with Visitor #2 on 05/29/18 at 4:10 PM. Visitor #2 stated that she arrived at the facility on 05/11/18 at approximately 5:00 PM and was informed by Visitor #1 that something was wrong with Resident #1. Visitor #2

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#1 stated she could not recall this specific visitor interaction.

On 5/11/18 after 5:00 PM, the therapist reported to Nurse #1 that Resident #1 was exhibiting slouched posture, drooling and slurred speech. Nurse #1 stated the NP assessed the resident in the morning and Resident #1 was on antibiotic therapy for a urinary tract infection.
On 5/11/18 at approximately 6:00 PM, Nurse #1 administered an antibiotic injection for Resident #1. At that time, Nurse #1 did not note observing facial drooping or drooling.

On 5/11/18 at the 7 PM shift change, Nurse #1 reported to medication aide (MA) #1. Nurse #1 and MA #1 did not report to a RN Resident #1's change in condition (right facial drooping, drooling, and continued slurred speech) for assessment, failing to follow established policy.

On 5/12/18 at approximately 10:08 AM, RN #1 assessed Resident #1. The assessment revealed Resident #1 had a change in condition (right facial drooping). RN #1 contacted Resident #1's physician/nurse practitioner provider. The provider gave an order to send Resident #1 to the emergency department (ED) for evaluation. RN #1 also contacted Resident #1's resident representative (RR)/daughter. RN #1 sent Resident #1 to the ED as ordered by the provider. The RR met Resident #1 at the ED. The resident representative/daughter reported

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stated that she observed Resident #1 in her wheelchair and was making all kinds of noises but her speech was slurred and she couldn't talk. Visitor #2 stated she went to look for someone to help Resident #1 and found Physical Therapist (PT) #1 and #2 and asked them to check on Resident #1.

An interview was conducted with PT #1 and PT #2 on 05/29/18 at 5:30 PM. PT #1 stated that on 05/11/18 at approximately 5:30 PM Visitor #2 came to the therapy gym and stated that Resident #1 had slurred speech, she had facial droop and was drooling. PT #1 indicated that she grabbed PT #2 and they went to check on Resident #1 and "found her to exhibit the same symptoms described" by Visitor #2. PT #1 stated that they went to Nurse #1 to inform her of Resident #1's condition. PT #1 stated that Nurse #1 stated that she was aware of Resident #1's condition and she had been seen by the NP earlier that day and was being treated for a UTI. PT #2 stated she again informed Nurse #1 of her concern with Resident #1's facial droop and again Nurse #1 stated she was aware. Both PT #1 and PT #2 did not see Nurse #1 assess Resident #1 and after they informed Nurse #1 of their concerns they returned to the therapy gym to complete their work.

An interview was conducted with Nurse #1 on 05/29/18 at 5:20 PM. Nurse #1 indicated that on 05/11/18 in report she was informed that the NP needed to evaluate Resident #1 because she was not acting like herself. Nurse #1 stated that she did not see or interact with Resident #1 that morning because she was passing medication and Resident #1 was not prescribed any medications. Nurse #1 stated around lunch time

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to the ED physician that Resident #1 was at baseline on 5/10/18. The resident representative/daughter also reported noticing right facial drooping on the morning of
5/12/18.

On 5/12/18 through 5/16/18, the ED physician evaluation, including laboratory and radiology test results indicated no evidence that Resident #1 had a cerebrovascular (CVA), “Workup here so far has been normal except the fact that she has been hypertensive, was also started on antibiotics for her urinary tract infections yesterday.” On 5/12/18, physician orders were given to discharge Resident #1 back to the facility with no medications ordered. The discharge diagnoses of CVA, do not resuscitate (DNR), dementia, hyperlipidemia, and hypertension are listed on the hospital discharge summary. Resolved diagnosis included acute cystitis without hematuria. On 5/16/18, Resident #1 returned to the facility with discharge instruction for hospice evaluation.

3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

On 5/30/18, the MDS RN and wound nurse RN assessed each resident. The RN assessment of each resident included taking vital signs, pain, and mental status

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F 684	Continued From page 19 the RA brought Resident #1 to me stated that she was not acting like herself and her speech was slurred. Nurse #1 indicated she was aware of her slurred speech and that the NP had seen her and ordered her an antibiotic for a UTI. Nurse #1 indicated that later in the day two PTs had come and stated that Resident #1 was not acting like herself and was exhibiting slurred speech, facial droop, and drooling. Nurse #1 stated that she replied to PT #1 and #2 that she had already been assessed and she was being taken care of. Nurse #1 stated that she did not think she needed to go and assess Resident #1 because the NP had already assessed her earlier in the day. A follow up interview was conducted with Nurse #1 on 05/31/18 at 10:26 AM. Nurse #1 confirmed again that she had not assessed Resident #1 for a change in condition and did not ask any other nurse to assess Resident #1. She acknowledged that the RA, Visitor #1, PT #1 and #2 had reported their concerns to her about Resident #1's slurred speech, facial droop, and drooling but she believed that they were all effects from her UTI. Nurse #1 stated that after the RA brought Resident #1 to her earlier that day she did not see Resident #1 again until 6:00 PM when she went to administer her ordered antibiotic injection and at that time she did not notice any change to her condition. An interview was conducted with Nursing Assistant (NA) #1 on 05/30/18 at 12:54 PM. NA #1 confirmed that she took care of Resident #1 on 05/11/18 on 1st and 2nd shift. She stated that Resident #1 was not acting like herself and her speech was slurred and she was drooling from one side of her mouth. NA #1 stated that she alerted Nurse #1 and was told that Resident #1	F 684	for change in condition. The purpose of the assessment was to protect Resident #1 and other residents in similar situations. The findings of the assessments: no current facility residents have a new/previously unidentified change in condition requiring additional assessment or physician/NP notification. On 5/30/18, the director of nursing (DON) initiated a re-education with all nursing staff to include nursing assistants (NAs), MAs, LPNs, and RNs. The re-education covered the topic of "Notification." "Notification of changes, Notification of MD/NP and RP. When alerted of a change in a resident, complete an assessment and document. Reporting changes include bruises of unknown origin…" On 5/30/18, the facility administrator and DON consulted with the regional vice president (RVP) and corporate RN facility consultant. The RVP and corporate consultant re-educated the administrator and DON. The re-education covered the topics of Quality of Care and the requirements for Notification of Changes. In addition, the RVP and corporate consultant reviewed with the administrator and DON topics of: 1) Change in Condition policy, 3) failure to assess for change of condition resulting from failure to follow established policy, and 4) the importance of addressing resident/family concerns related to quality of care. On 5/30/18, the corporate facility	

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F 684 Continued From page 20

had already been evaluated by the NP and was being treated for a UTI. NA #1 stated that she placed Resident #1 in the bed per her usual routine and when she left her shift at 11:00 PM on 05/11/18, Resident #1 was resting in bed with her eyes closed.

An interview was conducted with NA #2 on 05/30/18 at 11:54 AM. NA #2 confirmed that she worked 3rd shift on 05/11/18 and stated that Resident #1 rested in bed the entire night and she did not notice anything different with her. NA #2 stated that she rendered incontinent care to Resident #1 at approximately 5:00 AM on 05/12/18 but during that interaction she did not notice any usual behavior or anything out of the normal with Resident #1. She added that if she would have noticed any abnormal behavior she would have alerted the nurse.

An interview was conducted with Nurse #2 on 05/31/18 at 12:50 PM. Nurse #2 confirmed that he was working 3rd shift on 05/11/18 and was responsible for Resident #1. Nurse #2 stated that during report he was notified that Resident #1 had not been acting like herself but had been evaluated by the NP and was on antibiotic for UTI. Nurse #2 stated that Resident #1 rested throughout the night and he never had to interact with Resident #1 that night. He added that NA #2 did not report any unusual behavior that evening and it was a normal night for Resident #1.

An interview was conducted with Nurse #3 on 05/31/18 at 1:01 PM. Nurse #3 confirmed that she worked 05/12/18 on 1st shift and was responsible for Resident #1. Nurse #3 stated that approximately 10:00 AM Resident #1's family approached her and asked that Resident #1's

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consultant initiated a 100% audit of the nurse progress notes from 5/1/18 through 5/30/18. The purpose of the audit was to identify any needed resident assessment for Resident #1 or other resident at risk of a change of condition that has not been assessed and addressed through physician/NP provider notification and RR notification. Any resident needing assessment will be assessed by a RN and notifications made to the care provider and RR.

On 6/22/18, the corporate facility consultant re-educated the Interdisciplinary Team (IDT)- that includes but not limited to the DON, Staff Development Coordinator (SDC), treatment nurse, MDS Nurse, unit manager, activity director, rehab representative and social services - on the morning clinical meeting format, and follow up items process. Newly hired IDT members will receive training on the morning clinical meeting during orientation by the SDC.

The nurse that is assigned to the resident is responsible for the assessment of the resident when a change of condition has been identified. If the change occurs during a time when a RN is not on duty – the licensed nurse or the MA will call the RN on call and relay the pertinent data. The on-call RN will then be responsible for completing the assessment of the resident.

On 6/25/18, the DON began to re-educate

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F 684	Continued From page 21 vital signs be checked because there was something wrong with her. Nurse #3 stated that she had not seen Resident #1 prior to the family asking for her to check Resident #1's vital sings. Nurse #3 stated that when she went to obtain Resident #1's vital signs she did not notice any drooling or facial droop. She stated that she asked Resident #1 to smile and she did and she asked Resident #1 to lift both her arms in the air and she was able to do that. Nurse #3 stated that her assessment revealed no change in Resident #1 from her baseline but the family requested that Resident #1 be sent to the Emergency Room (ER) for evaluation and so she sent her out. An interview was conducted with Resident #1's family on 05/29/18 at 2:17 PM. The family member stated that she had visited Resident #1 on 05/10/18 and found her to be in her usual state of health. The family member stated that she came to the facility on 05/12/18 at approximately 10:15 AM and was sitting in the dining room waiting on the staff to get her family member dressed. She added that Visitor #1 came in and informed the family member of what she had witnessed on 05/11/18 with Resident #1. The family member stated that when Nurse #3 pushed her family member into the dining room and she observed her for the first time that day she instantly noticed her mouth was drawn to the right side and she stated she asked Resident #1 if she was okay and Resident #1 stated "no I am not okay." Resident #1's family member stated to Nurse #3 "is my family member ok she looks like she has had a stroke" and Nurse #3 replied "she looked like that this morning." Resident #1 stated she informed Nurse #3 she wanted her family member sent out to the ER for evaluation and they did.	F 684	the MAs, LPNs, and RNs on the process for assessment and change of condition and notification to the physician, physician extender and resident representative. Newly hired nurses and medications aides will receive the education on the assessment and change of condition and notification during their orientation period. The facility IDT will review in morning clinical meeting the progress notes dated from previous to current meeting to determine potential changes of conditions in resident conditions to include notification of physician and or Physician Extender and Resident Representative. The review will include copies of physician orders, clinical alerts that include meal intake, skin alerts, incidents, care plan updates or revisions, and resident and or family concerns. The DON will document any follow up items that require completion by end of day. The results of the daily IDT team meeting will be communicated to the administrator. To maintain continued the results of the follow-up items and compliance will be submitted to the facility's QAPI (quality assurance/performance improvement) Committee monthly for three months then quarterly for review and guidance. If additional issues are noted those issues will be addressed immediately and corrective action taken. 4. The title of the person responsible for implementing the acceptable plan of	

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F 684	Continued From page 22 An interview was conducted with NA #3 on 05/31/18 at 1:24 PM. NA #3 confirmed that she was working on 05/12/18 on 1st shift. NA #3 stated that Resident #1's family asked her to go and look at Resident #1. NA #3 stated that the instant she saw her she noticed her face was drawn to the right side and she looked like someone who had a stroke. NA #3 stated that she summoned the Director of Nursing (DON) to come and look at Resident #1 and she had her sent to the ER for evaluation. An interview was conducted with the DON on 05/30/18 at 3:30 PM. The DON stated that on the morning of 05/12/18 she arrived at the facility and NA #3 informed her that Resident #1's family member was in the facility and thought Resident #1 was having a stroke. The DON stated she immediately proceeded to go and check on Resident #1 and initially by looking at her could not tell anything was wrong but when Resident #1 started to speak she knew something was not right. The DON stated that Resident #1's speech was very slurred and she asked if the medics were on the way. She added that Nurse #3 stated that they were on the way to the facility and Resident #1 was transported to the ER for evaluation. The DON stated she was not aware that on 05/11/18 sometime after Resident #1 was evaluated by the NP she began to have facial droop and drooling and if these symptoms were reported to the nursing staff they should have contacted her. An interview was conducted with the Medical Doctor (MD) on 05/30/18 at 12:10 PM. The MD stated that if Resident #1 began to display facial droop, drooling, and slurred speech those were	F 684	correction. The administrator will be implementing and is responsible for implementing the acceptable plan of correction.	

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F 684	Continued From page 23 all classic signs of a stroke. The MD stated that if these symptoms were reported to the nursing staff on 05/11/18 the NP who was in the building should have been made aware so Resident #1 could have been reevaluated and sent immediately out to the ER. The MD stated that Resident #1 had returned to her baseline neurologically and physically and had done well while working with therapy. He added that when Resident #1 presented to the ER her scan of her brain was abnormal and indicated a stroke but could not determine how old. The MD added that because we could not identify when the stroke occurred or how old it was along with Resident #1's advanced age she would not have qualified for the treatment of tissue plasminogen activator (TPA) (treatment for stroke). Review of the discharge summary from the hospital dated 05/16/18 indicated that Resident #1 had presented to the ER on 05/12/18 and scan of her head revealed punctate age indeterminate lacunar infarcts (stroke) in the right basal ganglia and right thalamus (parts of the brain). Her readmitting diagnoses to the facility included CVA (stroke). An observation was made of Resident #1 on 05/30/18 at 12:10 PM. Resident #1 was sitting in her wheelchair in the common area. She was calm and no facial droop or drooling was noted. An observation was made of Resident #1 on 05/31/18 at 8:00 AM. Resident #1 was sitting at the breakfast table waiting to be served her meal. She was calm and pleasant and no facial droop or drooling was noted. Credible Allegation	F 684		

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F 684	Continued From page 24 5/31/18, 4:15 PM F684 1. The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited On 5/30/18, Clear Creek Nursing and Rehabilitation Center was placed into Immediate Jeopardy at 5:00 PM for failing to provide Quality of Care. The process that lead to the deficiency was determined to be the facility ' s failure to assess for change of condition when the licensed practical nurse (LPN, Nurse #1) did not report to a registered nurse (RN) for re-assessment of Resident #1 after receiving reports of the resident showing signs of facial drooping and drooling. The nurse recognized the resident ' s change in condition and believed the nurse practitioner addressed the resident ' s needs by performing an assessment and prescribing an antibiotic for the diagnosis of urinary tract infection. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/10/18, the MDS nurse's Care Plan - General Note indicated Resident #1 was at baseline and did not indicate Resident #1 with facial drooping or other change in condition. On 5/11/18, earlier in the day before 11 AM, Nurse #1 did observe Resident #1's change in clarity of speech and did not see any facial drooping or drooling earlier in the day and did call the nurse practitioner. Nurse #1 is a licensed practical nurse (LPN) and it is not in the scope of practice for an LPN to assess. Not recognizing	F 684		

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F 684	Continued From page 25 there was a change of condition, LPN #1 did not notify a registered nurse (RN), nurse practitioner (NP), or physician (MD) to re-assess Resident #1 in the afternoon as the day progressed on 5/11/18. On 5/11/18 at approximately 11:46 AM, the Physician Extender nurse practitioner (NP) note indicated Resident #1 was seen by the NP. The NP note indicated "Patient seen for acute care. Meds, labs, notes reviewed ...alert, confused ...UA reviewed, + for leukocytes, positive for nitrates ...patient refuses PO medications, give Rocephin 1-gram IM q24h x 3 doses, give with lidocaine." The NP note did not indicate Resident #1 with right facial drooping. On 5/11/18 at approximately 1:00 PM, the restorative aide noticed Resident #1's speech was not clear while weighing her and took the resident to Nurse #1. The restorative aide witnessed Nurse #1 looking at Resident #1 and watched Nurse #1 transport Resident #1 to the nurse station for observation. Nurse #1 did not document an assessment in the electronic health record. On 5/11/18 at approximately 2:45 PM, a different resident's family member reported that she attempted to approach Nurse #1 regarding Resident #1. Nurse #1 stated she could not recall this specific visitor interaction. On 5/11/18 after 5:00 PM, the therapist reported to Nurse #1 that Resident #1 was exhibiting slouched posture, drooling and slurred speech. Nurse #1 stated the NP assessed the resident in the morning and Resident #1 was on antibiotic therapy for a urinary tract infection. On 5/11/18 at approximately 6:00 PM, Nurse #1 administered an antibiotic injection for Resident #1. At that time, Nurse #1 did not note observing facial drooping or drooling.	F 684		

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F 684	Continued From page 26 On 5/11/18 at the 7 PM shift change, Nurse #1 reported to medication aide (MA) #1. Nurse #1 and MA #1 did not report to a registered nurse (RN) Resident #1's change in condition (right facial drooping, drooling, and continued slurred speech) for assessment, failing to follow established policy. On 5/12/18 at approximately 10:08 AM, registered nurse (RN) #1 assessed Resident #1. The assessment revealed Resident #1 had a change in condition (right facial drooping). RN #1 contacted Resident #1's physician/nurse practitioner provider. The provider gave an order to send Resident #1 to the emergency department (ED) for evaluation. RN #1 also contacted Resident #1's resident representative (RR)/daughter. RN #1 sent Resident #1 to the ED as ordered by the provider. The RR met Resident #1 at the ED. The resident representative/daughter reported to the ED physician that Resident #1 was at baseline on 5/10/18. The resident representative/daughter also reported noticing right facial drooping on the morning of 5/12/18. On 5/12/18 through 5/16/18, the ED physician evaluation, including laboratory and radiology test results indicated no evidence that Resident #1 had a cerebrovascular (CVA), "Workup here so far has been normal except the fact that she has been hypertensive, was also started on antibiotics for her urinary tract infections yesterday." On 5/12/18, physician orders were given to discharge Resident #1 back to the facility with no medications ordered. The discharge diagnoses of CVA, DNR, dementia, hyperlipidemia, and hypertension are listed on the hospital discharge summary. Resolved diagnosis included acute cystitis without hematuria. On 5/16/18, Resident #1 returned to the facility with discharge	F 684		

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F 684	Continued From page 27 instruction for hospice evaluation. 3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 5/30/18, the minimum data set (MDS) RN and wound nurse RN assessed each resident. The RN assessment of each resident included taking vital signs, pain, and mental status for change in condition. The purpose of the assessments was to protect Resident #1 and other residents in similar situations. The findings of the assessments: no current facility residents have a new/previously unidentified change in condition requiring additional assessment or physician/NP notification. On 5/30/18, the director of nursing (DON) initiated a re-education with all nursing staff to include nursing assistants (NAs), MAs, LPNs, and RNs. The re-education covered the topic of "Notification." "Notification of changes, Notification of MD/NP and RP. When alerted of a change in a resident, complete an assessment and document. Reporting changes include bruises of unknown origin ..." On 5/30/18, the facility administrator and DON consulted with the regional vice president (RVP) and corporate RN facility consultant. The RVP and corporate consultant re-educated the administrator and DON. The re-education covered the topics of Quality of Care and the requirements for Notification of Changes. In addition, the RVP and corporate consultant reviewed with the administrator and DON topics of: 1) Change in Condition policy, 3) failure to	F 684		

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F 684	Continued From page 28 assess for change of condition resulting from failure to follow established policy, and 4) the importance of addressing resident/family concerns related to Quality of Care. On 5/30/18, the corporate consultant initiate a 100% audit of the nurse progress notes from 5/1/18 through 5/30/18. The purpose of the audit was to identify any needed resident assessment for Resident #1 or other resident at risk of a change of condition that has not been assessed and addressed through physician/NP provider notification and RR notification. Any resident needing assessment will be assessed by a RN and notifications made to the care provider and RR. 4. The title of the person responsible for implementing the acceptable plan of correction. The administrator will be implementing and is responsible for implementing the acceptable plan of correction. Immediate jeopardy was removed on 05/31/18 at 5:53 PM when interviews with nursing staff revealed that they had been educated on conducting assessments when a change of condition was reported. The education also included if the nurse was unable to assess the resident that the expectation was that they report to a nurse that could assess the resident.	F 684		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality	F 770		6/29/18

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F 770	Continued From page 29 and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to obtain a resident's urine sample which was ordered by the physician for a culture and sensitivity for 1 of 3 residents reviewed for laboratory services (Resident #1). The findings included: Resident #1 was readmitted to the facility on 09/18/14 with diagnoses which included dementia and hypertension. Review of Resident #1's comprehensive Minimum Data Set (MDS) dated 02/23/18 revealed she was cognitively impaired and required limited assistance with most of her activities of daily living (ADLs). The MDS also indicated she was frequently incontinent of bladder and bowel. Review of Resident #1's Care Plan revised on 05/29/18 revealed in part a focus of urinary incontinence related to cognitive impairment, at risk for a urinary tract infection (UTI). Resident #1 will be free from a UTI by utilizing the interventions of encouraging adequate fluid intake, providing peri care after each incontinent episode and monitoring for and reporting signs	F 770	F 770 Laboratory Services The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited The position of Clear Creek Nursing and Rehabilitation Center regarding the process that led to the deficiency was determined to be the facility's failure to notify the physician/nurse practitioner of difficulty obtaining Resident #1's lab specimen to carry out the physician's order for urine culture and sensitivity. The facility obtained the specimen on 05/09/18 and the results were communicated to the Nurse Practitioner and appropriately addressed. The procedure for implementing the acceptable plan of correction for the specific deficiency cited An 100% audit was started 5/31/18 by the Director of Nursing (DON) of all laboratory order for the past 30 days to ensure laboratory samples were drawn, received, and communicated to physician in a timely manner. The audit was completed and revealed no further negative findings. The monitoring procedure to ensure that	

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F 770 Continued From page 30
and symptoms of UTIs.

Review of Resident #1's Physician's order dated 05/04/18 and noted by Nurse # 4 revealed an order to obtain a urine sample for culture and sensitivity (C&S which is a test to identify the germ and the antibiotic that will work best to inhibit the growth of the germ).

Review of Resident #1's Progress note written by Nurse # 4 and dated 05/09/18 at 14:58 PM stated "urine put in fridge for lab to pick up".

Review of Resident #1's Progress notes dated from 05/04/18 through 05/09/18 revealed no other documentation pertaining to the urine sample was noted.

On 05/31/18 at 12:17 PM an interview was conducted with Nurse #4 who stated when she received the order for Resident #1's urine culture (on 05/04/18) she tried two times before the end of her shift (7:00 PM) to obtain the urine but was unsuccessful because Resident #1 would not cooperate. The Nurse stated she reported it to Nurse #2 in report that she was unsuccessful. Also during the interview, Nurse #4 stated that on 05/09/18 she realized Resident #1's urine had not been obtained until a nurse aide brought it to her and she put the urine in the refrigerator.

On 05/31/18 at 12:50 PM during an interview with Nurse #2 he stated they tried several times to obtain a urine sample from Resident #1 during

F 770
the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

On 5/30/18, the director of nursing (DON) initiated a re-education with all nursing staff to include nursing assistants (NAs), MAs, LPNs, and RNs. The re-education covered the topic of “Notification.”

“Notification of changes, Notification of MD/NP and RP. When alerted of a change in a resident, complete an assessment and document. Reporting changes include bruises of unknown origin…”

On 5/30/18, the facility administrator and DON consulted with the regional vice president (RVP) and corporate RN facility consultant. The RVP and corporate consultant re-educated the administrator and DON. The re-education covered the topics of Quality of Care and the requirements for Notification of Changes to include notification of physician and or physician extender if lab specimens are not able to be obtained as ordered.

6/22/18 the Facility RN consultant re-educated the IDT (Interdisciplinary Team) on the morning clinical meeting format, and follow up items process.

The facility IDT (Interdisciplinary team) will review in morning clinical meeting the progress notes dated from previous to current meeting to determine potential

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CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227

(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) COMPLETION DATE
F 770	Continued From page 31 the shift of 7:00 PM to 7:00 AM on 05/04/18 but was unsuccessful. The Nurse admitted he did not notify the Medical Director (MD) or Nurse Practitioner (NP) that they were unable to obtain Resident #1's urine for C&S. On 05/31/18 at 1:24 PM an interview with Nurse Aide (NA) #3 was conducted. NA #3 stated she made several attempts to obtain a urine specimen from Resident #1 but she was unsuccessful. The NA continued to state that on 05/09/18 she was finally successful in obtaining the urine from Resident #1. On 05/10/18 the results of Resident #1's urine culture revealed she had a urinary tract infection and required an antibiotic for treatment. Interview with the Director of Nurses (DON) was conducted on 05/31/18 at 5:45 PM. She revealed the fact that Resident #1's urine could not be obtained after a few days, did not concern her as much as the fact that the NP was not notified that they were unable to obtain it. During an interview with the MD on 05/30/18 at 12:10 PM he stated he wrote the order to obtain Resident #1's urine for a C&S and if the urine could not be obtained within a day then he should have been notified.	F 770	changes of conditions in resident conditions to include notification of physician and or Physician Extender and Resident Representative. The review will include copies of physician orders including lab orders to include obtaining specimens and results, clinical alerts that include meal intake, skin alerts, incidents, care plan updates or revisions, and resident and or family concerns. The DON (Director of Nursing) will document any follow up items that require completion by end of day. The results of the daily IDT team meeting follow up will be communicated to the Administrator. To maintain continued the results of the Follow up items and compliance will be shared by the Administrator with the Facility's QA Committee monthly for three months then quarterly for review and guidance. If additional issues are noted those issues will be addressed immediately and corrective action taken 2. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing will be implementing and is responsible for implementing the acceptable plan of correction.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		6/29/18

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F 842	Continued From page 32 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842		

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F 842	Continued From page 33 §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to document unsuccessful attempts over 6-day period to obtain a urine sample as ordered by the physician for 1 of 3 residents (Resident #1) reviewed for accurate documentation. Findings included: Resident #1 was admitted to the facility on 09/18/14 with diagnoses that included dementia	F 842	F 842 Resident Records The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited The position of Clear Creek Nursing and Rehabilitation Center regarding the process that led to the deficiency was determined to be the facility's failure to document the difficulty obtaining Resident #1's lab specimen to carry out the physician's order for urine culture and	

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F 842

Continued From page 34

and hypertension.

Review of the most recent comprehensive Minimum Data Set (MDS) dated 02/23/18 revealed Resident #1 was cognitively impaired, had clear speech and was usually understood by others. The MDS further indicated Resident #1 required limited staff assistance with most activities of daily living and was frequently incontinent of both bladder and bowel.

Review of the physician orders for Resident #1 revealed an order dated 05/04/18 to obtain a urine sample for culture and sensitivity (test performed to identify the germs that cause the infection and what kind of medication will work best to treat the infection).

Review of the nurse progress notes for the period 05/04/18 through 05/09/18 revealed an entry dated 05/09/18 which read, "urine put in fridge for lab to pick up." Further review revealed no other entries regarding attempts to obtain a urine sample.

Review of the urine culture results for Resident #1 dated 05/10/18 revealed she had a urinary tract infection and required an antibiotic for treatment.

During an interview on 05/31/18 at 12:17 PM Nurse #4 revealed she received an order on 05/04/18 to obtain a urine sample for Resident #1 and made 2 attempts before the end of her shift

F 842

sensitivity.

The facility obtained the specimen on 05/09/18 and the results were communicated to the Nurse Practitioner and appropriately addressed.

The procedure for implementing the acceptable plan of correction for the specific deficiency cited
An 100% audit was started 5/31/18 by the Director of Nursing (DON) of all laboratory orders and progress notes for the past 30 days to ensure laboratory samples were drawn, received, and communicated to physician in a timely manner. The audit was completed and revealed no further negative findings.

The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements

On 5/30/18, the director of nursing (DON) initiated a re-education with all nursing staff to include nursing assistants (NAs), MAs, LPNs, and RNs. The re-education covered the topic of “Documentation” to include documentation of inability to obtain lab specimens and notification of the physician of inability to obtain.
On 5/30/18, the facility administrator and DON consulted with the regional vice president (RVP) and corporate RN facility consultant. The RVP and corporate consultant re-educated the administrator and DON. The re-education covered the

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F 842	Continued From page 35 at 7:00 PM but was unsuccessful because Resident #1 would not cooperate. Nurse #4 confirmed she reported the unsuccessful attempts to obtain the urine sample to Nurse #2 during shift report but did not document it in Resident #1's medical record. During an interview on 05/31/18 at 12:50 PM Nurse #2 revealed staff tried several times to obtain a urine sample from Resident #1 during the shift 7:00 PM to 7:00 AM on 05/04/18 but was unsuccessful. Nurse #2 confirmed he did not document the attempts to obtain a urine sample in Resident #1's medical record. During an interview on 05/31/18 at 1:24 PM Nurse Aide (NA) #2 was unable to recall the exact day she was informed by the Nurse to obtain a urine sample from Resident #1 but did recall making several unsuccessful attempts over the "course of 3 days." NA #2 added she was finally successful in obtaining the urine sample from Resident #1 on 05/09/18. During an interview on 05/31/18 at 5:45 PM the Director of Nursing (DON) indicated staff should have notified the medical provider within 24 hours of receiving the order when they were unable to obtain a urine sample for Resident #1. The DON added she would have expected for staff to clearly document in Resident #1's medical record attempts made and why the urine sample was unable to be obtained.	F 842	topics of Quality of Care and the requirements for Notification of Changes to include notification/ documentation of physician and or physician extender if lab specimens are not able to be obtained as ordered. 6/22/18 the Facility RN consultant re-educated the IDT (Interdisciplinary Team) on the morning clinical meeting format, and follow up items process. The facility IDT (Interdisciplinary team) will review in morning clinical meeting the progress notes dated from previous to current meeting to determine potential changes of conditions in resident conditions to include notification of physician and or Physician Extender and Resident Representative. The review will include copies of physician orders including lab orders to include obtaining specimens and results, clinical alerts that include meal intake, skin alerts, incidents, care plan updates or revisions, and resident and or family concerns. The DON (Director of Nursing) will document any follow up items that require completion by end of day. The results of the daily IDT team meeting follow - up will be communicated to the Administrator. To maintain continued the administrator will share the results of the Follow up items and compliance will be submitted to the Facility's QA Committee monthly for three months then quarterly for review and guidance. If additional issues are noted those issues will be addressed immediately and	

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F 842	Continued From page 36	F 842	corrective action taken 2. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing will be implementing and is responsible for the acceptable plan of correction.	

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{F 000}	INITIAL COMMENTS 483.25 (F684) at J See event ID HCFX11 dated 5/31/2018. An extended survey was conducted as part of the facility's follow-up survey and complaint investigation from 05/29/18 to 05/31/18. Event ID# QMN712. A revisit was conducted from 05/29/18 to 05/31/18 and the facility remains out of compliance.	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: See citation at F 684, event HCFX11 dated 5/31/2018. There is continued noncompliance at this regulation.	{F 684}	Clear Creek Nursing and Rehab acknowledges 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 residents. The Plan of Correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehab response to this Statement of Deficiencies does not denote agreement	6/29/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/22/2018

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.

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{F 684}	Continued From page 1	{F 684}	with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Clear Creek Nursing and Rehab 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 proceeding. F684 Quality of Care 1. The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited On 5/30/18, Clear Creek Nursing and Rehabilitation Center was placed into Immediate Jeopardy at 5:00 PM for failing to provide quality of care. The process that lead to the deficiency was determined to be the facility's failure to assess for change of condition when the licensed practical nurse (LPN, Nurse #1) did not report to a registered nurse (RN) for re-assessment of Resident #1 after receiving reports of the resident showing signs of facial drooping and drooling. 2. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5/10/18, the minimum data set (MDS) nurse's care plan – General Note	

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{F 684}	Continued From page 2	{F 684}	indicated Resident #1 was at baseline and did not indicate Resident #1 with facial drooping or other change in condition. On 5/11/18 earlier in the day before 11 AM, Nurse #1 did observe Resident #1's change in clarity of speech, but did not see any facial drooping or drooling, and then called the nurse practitioner to verify the nurse practitioner would be at the facility on 5/11/18. Nurse #1 is a LPN and it is not in the scope of practice for an LPN to assess. On 5/11/18 at approximately 11:46 AM, the physician extender nurse practitioner (NP) note indicated Resident #1 was seen by the NP. The NP note indicated "Patient seen for acute care. Meds, labs, notes reviewed…alert, confused…UA reviewed, + for leukocytes, positive for nitrates…patient refuses PO medications, give Rocephin 1 gram IM q24h x 3 doses, give with lidocaine." The NP note did not indicate Resident #1 with right facial drooping. On 5/11/18 at approximately 1:00 PM, the restorative aide noticed Resident #1's speech was not clear while weighing her and took the resident to Nurse #1. On 5/11/18, at approximately 1:00 PM, the restorative aide witnessed Nurse #1 looking at Resident #1 and watched Nurse #1 transport Resident #1 to the nurse station for observation. Nurse #1 did not document her observation of Resident #1 in the electronic health	

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{F 684}	Continued From page 3	{F 684}	record. Not recognizing there was a change of condition, LPN #1 did not notify a registered nurse (RN), NP, or physician (MD) to re-assess Resident #1 in the afternoon as the day progressed on 5/11/18. On 5/11/18 at approximately 2:45 PM, a different resident's family member reported that she attempted to approach Nurse #1 regarding Resident #1. Nurse #1 stated she could not recall this specific visitor interaction. On 5/11/18 after 5:00 PM, the therapist reported to Nurse #1 that Resident #1 was exhibiting slouched posture, drooling and slurred speech. Nurse #1 stated the NP assessed the resident in the morning and Resident #1 was on antibiotic therapy for a urinary tract infection. On 5/11/18 at approximately 6:00 PM, Nurse #1 administered an antibiotic injection for Resident #1. At that time, Nurse #1 did not note observing facial drooping or drooling. On 5/11/18 at the 7 PM shift change, Nurse #1 reported to medication aide (MA) #1. Nurse #1 and MA #1 did not report to a RN Resident #1's change in condition (right facial drooping, drooling, and continued slurred speech) for assessment, failing to follow established policy. On 5/12/18 at approximately 10:08 AM, RN #1 assessed Resident #1. The	

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{F 684}	Continued From page 4	{F 684}		

assessment revealed Resident #1 had a change in condition (right facial drooping). RN #1 contacted Resident #1's physician/nurse practitioner provider. The provider gave an order to send Resident #1 to the emergency department (ED) for evaluation. RN #1 also contacted Resident #1's resident representative (RR)/daughter. RN #1 sent Resident #1 to the ED as ordered by the provider. The RR met Resident #1 at the ED. The resident representative/daughter reported to the ED physician that Resident #1 was at baseline on 5/10/18. The resident representative/daughter also reported noticing right facial drooping on the morning of 5/12/18.

On 5/12/18 through 5/16/18, the ED physician evaluation, including laboratory and radiology test results indicated no evidence that Resident #1 had a cerebrovascular (CVA), "Workup here so far has been normal except the fact that she has been hypertensive, was also started on antibiotics for her urinary tract infections yesterday." On 5/12/18, physician orders were given to discharge Resident #1 back to the facility with no medications ordered. The discharge diagnoses of CVA, do not resuscitate (DNR), dementia, hyperlipidemia, and hypertension are listed on the hospital discharge summary. Resolved diagnosis included acute cystitis without hematuria. On 5/16/18, Resident #1 returned to the facility with a discharge instruction for hospice evaluation.

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{F 684}	Continued From page 5	{F 684}	3. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 5/30/18, the MDS RN and wound nurse RN assessed each resident. The RN assessment of each resident included taking vital signs, pain, and mental status for change in condition. The purpose of the assessment was to protect Resident #1 and other residents in similar situations. The findings of the assessments: no current facility residents have a new/previously unidentified change in condition requiring additional assessment or physician/NP notification. On 5/30/18, the director of nursing (DON) initiated a re-education with all nursing staff to include nursing assistants (NAs), MAs, LPNs, and RNs. The re-education covered the topic of “Notification.” “Notification of changes, Notification of MD/NP and RP. When alerted of a change in a resident, complete an assessment and document. Reporting changes include bruises of unknown origin…” On 5/30/18, the facility administrator and DON consulted with the regional vice president (RVP) and corporate facility consultant. The RVP and corporate facility consultant re-educated the	

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	345562	A. BUILDING ______ B. WING ______	R-C 05/31/2018

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{F 684}	Continued From page 6	{F 684}	administrator and DON. The re-education covered the topics of Quality of Care and the requirements for Notification of Changes. In addition, the RVP and corporate facility consultant reviewed with the administrator and DON topics of: 1) Change in Condition policy, 3) failure to assess for change of condition resulting from failure to follow established policy, and 4) the importance of addressing resident/family concerns related to quality of care. On 5/30/18, the corporate facility consultant initiated a 100% audit of the nurse progress notes from 5/1/18 through 5/30/18. The purpose of the audit was to identify any needed resident assessment for Resident #1 or other resident at risk of a change of condition that has not been assessed and addressed through physician/NP provider notification and RR notification. Any resident needing assessment will be assessed by a RN and notifications made to the care provider and RR. On 6/22/18, the corporate facility consultant re-educated the Interdisciplinary Team (IDT)- that includes but not limited to the DON, Staff Development Coordinator (SDC), treatment nurse, MDS Nurse, unit manager, activity director, rehab representative and social services- on the morning clinical meeting format, and follow up items process. Newly hired IDT members will receive training on the morning clinical meeting during orientation	

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{F 684}	Continued From page 7	{F 684}	by the SDC. The nurse that is assigned to the resident is responsible for the assessment of the resident when a change of condition has been identified. If the change occurs during a time when a RN is not on duty – the licensed nurse or the MA will call the RN on call and relay the pertinent data. The on-call RN will then be responsible for completing the assessment of the resident. On 6/25/18, the DON began to re-educate the MAs, LPNs, and RNs on the process for assessment and change of condition and notification to the physician, physician extender and resident representative. Newly hired nurses and medications aides will receive the education on the assessment and change of condition and notification during their orientation period. The facility IDT will review in morning clinical meeting the progress notes dated from previous to current meeting to determine potential changes of conditions in resident conditions to include notification of physician and or physician extender and resident representative. The review will include copies of physician orders, clinical alerts that include meal intake, skin alerts, incidents, care plan updates or revisions, and resident and or family concerns. The DON will document any follow up items that require completion by end of day. The results of the daily IDT team meeting will be communicated to the administrator.	

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{F 684}	Continued From page 8	{F 684}	To maintain continued the results of the follow-up items and compliance will be submitted to the facility's QAPI (quality assurance/performance improvement) Committee monthly for three months then quarterly for review and guidance. If additional issues are noted, those issues will be addressed immediately and corrective action taken. 4. The title of the person responsible for implementing the acceptable plan of correction. The administrator will be implementing and is responsible for implementing the acceptable plan of correction.	
{F 867} SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff, visitor, family, Nurse Practitioner, and Medical Doctor interviews the facility ' s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place in April 2018 following the facility ' s	{F 867}	F 867 QAPI Committee The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation center regarding the	6/29/18

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{F 867}

Continued From page 9

recertification and complaint survey. The repeat deficiency is in the area of quality of care (F684). This deficiency was recited on the facility ' s current follow up and complaint survey. The continued failure of the facility during 2 federal surveys of record show a pattern of the facility ' s inability to sustain an effective Quality Assurance Program.

The findings included:

This tag is cross referred to:

F684: Based on observations, record reviews, staff, visitor, family, Nurse Practitioner, and Medical Doctor interviews the facility failed to assess a resident that exhibited signs and symptoms of cerebrovascular accident (stroke) for 1 of 3 residents sampled for quality of care (Resident #1).

During the recertification survey of 04/18/18, this regulation was cited for failing to provide the appropriate size of wheel chair for proper body alignment for 1 of 4 sampled residents who required assistance with positioning (Resident #48).

An interview was conducted with the Administrator on 05/31/18 at 6:38 PM. The Administrator stated he had been at the facility for a couple of months and he oversaw the Quality Assessment (QA) meeting. He explained that it was held monthly and consisted of the Administrator, Director of Nursing, all department heads, medical director, nurse practitioner, pharmacist, and Registered Dietitian. The Administrator explained that their last meeting was 05/16/18 and they discussed the results of

{F 867}

process that lead to the deficiency of failed to maintain implemented procedures and monitor interventions - was failure to follow established facility policy related to quality assurance/performance improvement process (QAPI).

The procedure for implementing the acceptable plan of correction for the specific deficiency cited

On 6/20/18, the facility monthly QAPI Committee held a meeting to review the purpose and function of the QAPI Committee and review on-going compliance issues. The Administrator, director of nursing (DON), minimum data set (MDS) nurse, staff facilitator, maintenance director, dietary manager, activities director, quality improvement (QI) nurse and housekeeping supervisor will attend monthly and quarterly QAPI committee meetings on an ongoing basis and will assign additional team members as appropriate.

On 6/20/18, the facility quarterly Executive QAPI Committee held a meeting to review the tags from the most recent survey and go over the general plan of correcting the deficiencies with the medical director and corporate facility consultant.

On 6/20/18, the corporate facility consultant in-serviced the outgoing administrator and oncoming administrator related to the appropriate functioning of

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{F 867}	Continued From page 10 their recertification survey and discussed how the audits and monitoring tools were going. He added that the audits were going well and he was holding all staff even weekend staff accountable so that the facility could achieving the compliance they want. The Administrator added that they hold ad hoc meetings as needed if the team identity ' s a soft spot or area of concern the team will come together and discuss the issue. He added that often they will seek the advice of the Medical Director. The Administrator stated that he would be meeting with his team soon to discuss the survey results and to formulate a plan that would steer the team in the right direction.	{F 867}	the Executive QAPI Committee and the purpose of the committee to include identifying issues and correct repeat deficiencies related to F 684. On 6/20/18, the administrator in-serviced the department heads related to the appropriate functioning of the QAPI committees and the purpose of the committees to include identifying issues and correct repeat deficiencies related to F684. As of 6/20/18 after the facility consultant in-service, the facility QAPI committee will begin identifying other areas of quality concern through the QAPI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (electronic health record), review of resident council minutes, review of resident concern logs, review of pharmacy reports, and review of regional facility consultant recommendations. The QAPI Committee will meet at a minimum of monthly and Executive QAPI Committee will meet a minimum of quarterly to identify issues related to quality care, quality of life, safety, trends, analysis, and will develop and implement systematic corrective actions plans for identified facility concerns. Corrective action has been taken for the identified concerns related to F 684.	

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{F 867}	Continued From page 11	{F 867}	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The Executive QAPI Committee which includes but is not limited to the Administrator, Medical Director, Quality Improvement Coordinator, Social Worker, Director of Nursing, Pharmacist consultant, Medical Records Director, Dietary Manager and Housekeeping Supervisor will continue to meet at a minimum of Quarterly to review information concerning resident care, environment of the facility, medical records, dietary services, activities, social services and general resident and family satisfaction. The QAPI committee which includes but is not limited to the Administrator, Director of Nursing, Social Services, Activity Director, Infection Control Nurse, Maintenance Director, Housekeeping Supervisor and other staff members as assigned by the Administrator. The QAPI committee will continue to meet monthly to discuss the QI Program progress that is centered on the needs and desires of our resident. The QAPI Committee reviews progress of the standing QI committees with oversight by a corporate staff member. The Executive QAPI Committee, including the medical director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The	

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{F 867}	Continued From page 12	{F 867}	Executive QAPI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction The administrator is responsible for implementation of the acceptable plan of correction.	