DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FOR	MAPPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY
		345562	B. WING		0	C 7/ 02/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
CLEAR C	REEK NURSING & R	EHABILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE /INT HILL, NC 28227	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279 SS=G	to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an needs that are iden assessment. The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident" §483.10, including funder §483.10(b)(4) This REQUIREMEN by: Based on observat record review, the f resident 's increase included goals and prevention for 1 of 3 reviewed for skin in Findings included: Resident #3 was ac diagnoses of difficu muscle weakness,	A construction of the services that are train or maintain the resident's in of care. Velop a comprehensive care ent that includes measurable tables to meet a resident's ind mental and psychosocial tified in the comprehensive a describe the services that are train or maintain the resident's physical, mental, and eing as required under ervices that would otherwise (483.25 but are not provided as exercise of rights under the right to refuse treatment b). NT is not met as evidenced ions, staff interviews and acility failed to care plan a ed risk of skin tears that interventions for skin tear 3 residents (Resident #3) inpairment. I mitted on 3/31/15 with lty walking, generalized chronic hypotension,	F 2	279	Clear Creek Nursing and Rehabilitation Center acknowledges receipt of the statement of Deficiencies and proposes this Plan of Correction to the ectent that the summay 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.	
	Progress notes for Resident #3 had be	ilure and hypertension. 3/31/15 3:47 PM indicated en admitted with skin tears to			Clear Creek Nursing and Rehabilitation CenterKs response to this Statement of	(X6) DATE
	DIRECTORS OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NALUKE		TITLE	(A0) DAIE

(X6) DATE

PRINTED: 08/10/2015

07/24/2015

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.

Electronically Signed

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. (X3) DATE	
	F CORRECTION	IDENTIFICATION NUMBER:				PLETED
		345562	B. WING		07/02/2015	
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR C	REEK NURSING & R	EHABILITATION CENTER		0506 CLEAR CREEK COMMERCE DRIVE IINT HILL, NC 28227	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 279	Continued From pa	ae 1	F 279			
	top of his left wrist, Review of the 4/7/1 Set (MDS) indicated cognitively impaired of care. The MDS extensive assistance use, and personal h Progress notes for Resident #3 had su elbow during a tran wheelchair. The nu was resistive to car living and transfers, or plan initiated to p sustaining skin tear On 4/10/15 at 11:59 the treatment nurse Resident #3 ' s righ Resident #3 ' s othe documented Reside The intervention do see if the resident ' adjustment. There indicated the nurse medication. Review of a nursing 11:24 AM indicated s attention an open	right hand and right wrist. 5 Admission Minimum Data d Resident # 3 was severely d with no behaviors or rejection revealed the resident required the for transfer, dressing, toilet hygiene. 4/10/15 at 9:32 AM indicated stained a skin tear to his right sfer from bed to the urse documented Resident #3 e during activities of daily . There were no interventions prevent Resident #3 from		Deficiencies does not denote agr with the Statement of Deficiencie does it constitute an admission the deficiency is accurate. Further, C Creek Nursing and Rehabilitation reserves the right to refute any of deficiencies on this Statement of Deficiencies through Informal Dis Resolution, formal appeal proced and/or any other administrative of proceeding. F279 Develop Comprehensive Care Pl Criteria 1 Resident #3 discharged on 7/9/20 Criteria 2 100% Audit was completed on 7/ all residents with skin tears by Ml nurses, Assistant Director of Nurs Staff Facilitator and Director of Nurs a preventative assessment comp licensed nurses by 7/22/15. On 5 the Staff Facilitator initiated a 10 in-servicing of licensed nursing s how to complete preventative	s nor hat any lear f the spute dure r legal ans 015 22/15 of DS sing, ursing. red based s will have bleted by 7/16/15, 0%	
	applied a hydrocollo were put into place Review of the care identification that R	area with normal saline and bid dressing. No measures to prevent further skin tears. plan did not reveal any esident #3 had a problem with ded no interventions for ears.		assessments on admission and c interventions initiated based on th findings. All incidents will have in interventions by a license Nurse. 7/16/15, MDS nurses in-serviced Director of Nursing on updating C for actual and at risk for skin tear	ne nmediate On by Care plan	
	NA #2 was interview The NA stated she	ved on 6/30/15 at 1:21 PM. cared for Resident #3 each ich was usually 5 times per		Criteria 3 The Director of Nursing, Assistar		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 070226

PRINTED: 08/10/2015 FORM APPROVED OMB NO 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	E SURVEY PLETED
		345562	B. WING		07/02/2015	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	10	IREET ADDRESS, CITY, STATE, ZIP COD 0506 CLEAR CREEK COMMERCE DR IINT HILL, NC 28227	E IVE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 279 F 280 SS=E	resident to get skin transferred Resider the path was clear this skin. The NA s residents were four at the nurse ' s stati #3 ' s care guide an guide did not includ who are at risk for s During an interview 2:30 PM, she stated protocols covered the She added it was the nurse to care plan s An interview was he (DON) and MDS Nu The DON stated shiskin tears to be add DON reviewed the of not see a care plan problem for Residen interventions for ski identify the resident as caused by a skir care guide, identifie caring for residents of skin tears and intervention was not for Resident 3. The no explanation why or interventions to p been addressed or care guide. 483.20(d)(3), 483.1 PARTICIPATE PLA	was not unusual for the tears. NA #2 when she at #3 she tried to make sure to avoid having any object hit tated instructions for caring for ad on the care guides located ion. NA #2 reviewed Resident ad acknowledged the care e information about residents skin tears with Nurse #1 on 6/30/15 at d the facility 's wound care he treatment of skin tears. he responsibility of the MDS skin tears. eld with the Director of Nursing urse #1 on 7/1/15 at 1:30 PM. e expected Resident #3 's dressed on the care plan. The care plan and stated she did identifying skin tears as a nt #3, did not identify in tear prevention and did not t's current wound identified hear. The DON reviewed the ed to be used by the NAs for and stated the resident's risk terventions for skin tear identified on the care guides e MDS nurse stated she had the skin tear on the left shin prevent skin tears had not Resident #3 's care plan or		Director of Nursing, Staff Facil MDS Nurses will monitor all ne admissions, and any incidents care plans and care guides are with interventions. This will be during clinical meeting Monday one week, then weekly for one then monthly for two months. audits will be reviewed in the d meeting M-F. Criteria 4 The Director of Nursing or Qua Improvement nurse will report results to the Executive Quality Improvement Committee. The will review the results of the au monthly and make recommend needed for continued compliar area and to determine the nee or/ frequency of continued QI r	ew to ensure e updated completed y-Friday for month, Incident aily ality the audit y committee idits dations as nce in this d for and	7/27/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 070226

If continuation sheet Page 3 of 30

PRINTED: 08/10/2015 FORM APPROVED OMB NO 0938 0301

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	1 APPROVED 0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		TE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		MPLETED
		345562	B. WING			C / 02/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
CLEAR O	REEK NURSING & R	EHABILITATION CENTER		10506 CLEAR CREEK COMMERCE I MINT HILL, NC 28227	ORIVE	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)		COMPLETION DATE
F 280	Continued From no	ao 2	F 28			
1 200	F 280 Continued From page 3 incompetent or otherwise found to be		F 20	50		
		the laws of the State, to				
		ng care and treatment or				
	changes in care and	d treatment.				
	A comprehensive c	are plan must be developed				
		he completion of the				
		essment; prepared by an m, that includes the attending				
		red nurse with responsibility				
		d other appropriate staff in				
		mined by the resident's needs, racticable, the participation of				
	the resident, the res	sident's family or the resident's				
		; and periodically reviewed				
	and revised by a tea	am of qualified persons after				
		NT is not met as evidenced				
	by: Based on interview	s with staff and record review		F280		
		revise the care plans for 2 of 3		Right To Participate Planning	g Care-Revise	9
	```	#3 and Resident #4)		CP		
	reviewed for falls. Findings included:			Criteria 1 Care plan and care guide up	dated by	
		admitted on 2/6/15 with		MDS Nurse to include fall int		r
	diagnoses that inclu	uded personal history of fall,		Resident #4 on 7/21/15.		
		weakness, diabetes, natoid arthritis, lack of		Resident #3 discharged on 7	/9/2015	
	coordination and hy			Criteria 2		
	The fall care plan f	or Resident #4, with a created		100% Audit of all residents		
		icated the goal was she would		risk evaluation completed by		
		nterventions added in h 2015 included anti-roll back		nurse, and care plan and car updated by MDS Nurses bas		
		elchair, assist during transfer		findings by 7/22/15 On 7/16/		
		low position, fall risk protocol		Facilitator initiated a 100% in		

Facility ID: 070226

If continuation sheet Page 4 of 30

PRINTED: 08/10/2015

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
			A. BUILDING		с		
		345562	B. WING			02/2015	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 280	have commonly usikeep call light within intervene for factors resident to wear pro- during transfers. The Admission Min 2/13/15, revealed F intact. She was co- assistance with tran- for ambulation in he unit. The MDS also only able to stabilized uring transition an- identified as having Review of nurse 's at 4:37 AM, revealed her knees between Education for the re- preventative intervers sleep and locking w chair for support, w Nurse 's progress PM indicated Resided with no injuries. The interventions were a reminders to call for urine collection sys Review of the facilite #4 had fallen on 4/2 plan was revised at monitor for routine The resident 's car 4/23/15, indicated to supervision only. U	what the protocol entailed), ed articles within easy reach, n easy reach, monitor and s causing falls and educate oper and non-slip footwear imum Data Set (MDS), dated Resident #4 was cognitively oded as requiring limited nsfers, extensive assistance er room and locomotion on the p indicated Resident #4 was e with human assistance d walking. Resident #4 was falls since her admission. progress notes, dated 4/14/15 ed Resident #4 was found on wheelchair and the bed. esident and family on entions, such as lying down to wheelchair when using the rere added to the care plan. notes dated 4/21/15 at 7:53 lent #4 had 2 falls that shift he care plan revealed added to include frequent r assistance and to empty the tem after each meal. ty ' s fall log indicated Resident 23/15. On 4/23/15, the care nd staff were instructed to	F 28	<ul> <li>licensed nursing staff on ho falls assessments on admis quarterly and as needed, w interventions based on the f incidents will have immediat interventions by a License N 7/16/15, MDS nurses in-ser Director of Nursing on upda Plans and Care Guides to ir interventions</li> <li>Criteria 3 The Director of Nursing, Ass Director of Nursing, Staff Fa MDS Nurses will monitor all admissions, and any incider care plans and care guides with interventions. This will during clinical meeting Mon- one week, then weekly for c then monthly for two months audits will be reviewed in the meeting M-F.</li> <li>Criteria 4</li> <li>The Director of Nursing or C Improvement nurse will repor results to the Executive Qua Improvement Committee. T will review the results of the monthly and make recommen- needed for continued comp area and to determine the n or/ frequency of continued C</li> </ul>	sion and ith indings. All te Jurse. On viced by ting Care nclude new sistant acilitator, and new nts to ensure are updated be completed day-Friday for one month, s. Incident e daily Quality port the audit ality The Committee audits endations as liance in this eed for and		

Facility ID: 070226

If continuation sheet Page 5 of 30

STATEMENT	OF DEFICIENCIES OF CORRECTION	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED
		345562	B. WING		C 07/02/2015	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	MINT HILL, NC 28227 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 280	assistance (based i items in reach, non ambulation. Resident #4 ' s Qua (MDS), dated 5/15/ severely cognitively assistance was req limited assistance was the room, supervisi the corridor and limi locomotion was rec off the unit. The Mi requiring extensive personal hygiene. identified with falls assessment that nu injury. Review of nurse ' s revealed during cha notified Resident #4 interventions were prevent further falls Nurse ' s notes date indicated staff repo floor. Review of pro- revealed no new in On 6/1/15 at 1:28 F therapy had notified was found sitting on nurse documented the importance of p when she needed t On 6/2/15, the care included an interve- to use a urinal to er system. Nurse ' s notes for the nurse was called	on cognition), keep personal -skid footwear and supervised arterly Minimum Data Set 15, indicated the resident was vimpaired. Extensive uired for transfer, bed mobility, was required when walking in on was needed for walking in uited assistance with quired with locomotion on and DS identified Resident #4 as assistance with toilet use and The resident was also since admission or the prior umbered 2 or more with no notes for 5/29/15 at 9:28 AM, ange of shift, the nurses were 4 was on the floor. No added on the care plan to	F 2	80		

If continuation sheet Page 6 of 30

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLI	E CONSTRUCTION		E SURVEY	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED	
		345562	B. WING _				C 02/2015	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CLEAR C	REEK NURSING & R	EHABILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE			
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX		PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	(	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		COMPLETION DATE		
F 280	Continued From pa	ge 6	F 28	80				
	added to the care p	lan						
		PM, nurse 's notes indicated						
		se heard Resident #4 calling documented she found the						
		the side rail with her buttocks						
		I with feet on the floor						
		ncouraged to use the call light. are added to the care plan.						
		PM, MDS Nurse #1 and the						
		(DON) were interviewed.						
		ited information about resident uring the morning department						
		he added she was unaware						
	Resident #4 had fal	llen on 6/18/15. Review of the						
		and the MDS nurse revealed						
		nt reports or investigations for ne stated without an incident						
	report, an investiga	tion would not be completed						
		ould not be placed to prevent						
	further falls. A telephone intervie	ew was held with Nurse #5 on						
		She stated she did not						
		cifics about the resident's						
		dded Resident #4 tried to go to rself and has been educated						
		for assistance. The nurse						
	stated most of the t	ime the resident was alert and						
		equent urinary tract infections						
		r confusion and her falls. Iltiple intervention were used						
		uding 1 to 1 observation or to						
	place the resident in	n a common area for						
		ions. Review of the nurse 's						
	observations.	al documentation of 1 to 1						
	2. Resident #3 wa	s admitted on 3/31/15 with						
	diagnoses of difficu	Ity walking, atrial fibrillation,						
	generalized muscle	weakness, chronic						

If continuation sheet Page 7 of 30

PRINTED: 08/10/2015

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY	
		345562	A. BUILDING		C		
		545562			07/02/2015		
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIC DATE	
F 280	failure. Nurse 's notes dat revealed Resident nurse noted upon e was found to be sit wheelchair. She ne floor back to his be Review of nurse 's revealed the reside and his call light wa Nurse 's notes for the nurse had beer assistant (NA) that in the floor in front intervention was to The care plan for F 4/28/15 indicated th The goal of not sus the next review wa during transfer and position (4/2/15), re (4/18/15), fall risk p reach and answer frequent reminders assistance before o On 5/20/15 at 9:22 nurse 's notes that sitting on the floor i There were no inte plan. An interview was h (DON) and the MD	red 4/15/15 at 4:00 PM, #3 yelled out for help. The entering the room, Resident #3 ting on the floor in front of his oted she assisted him from the ed. a notes for 4/16/15 at 6:13 PM ent ' s bed was in low position as in place. 4/17/15 at 8:39 PM indicated n notified by the nursing Resident #3 was found sitting of his wheelchair. The	F 280				

If continuation sheet Page 8 of 30

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF		ATE SURVEY		
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G Ci	OMPLETED		
		345562	B. WING		C 07/02/2015		
NAME OF I	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE			
CLEAR (	CREEK NURSING & R	EHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE		
	cognitively impaired #1 stated education intervention for Res cognitive status. T should be revised v Review of the care had been added to had no explanation been revised. 483.25 PROVIDE 0	ad been assessed as severely d. The DON and MDS Nurse n was not an appropriate sident #3 based on his The DON stated the care plan within 24 hours after a fall. plan revealed the 5/20/15 fall the care plan. MDS nurse #1 why the care plan had not CARE/SERVICES FOR	F 280 F 309		7/27/15		
SS=G	Each resident must provide the necess or maintain the high mental, and psycho	t receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in e comprehensive assessment					
	by: Based on observation interviews with a fareview, the facility for prevention of skin t (Resident #3) revier tear resulted in an of Findings included: Resident #3 was and diagnoses of difficult muscle weakness, congestive heart far Progress notes for Resident #3 had be	NT is not met as evidenced tions, staff interviews, mily member and record ailed to place interventions for ears for 1 of 1 resident wed for skin tears, whose skin unstageable wound. dmitted on 3/31/15 with lity walking, generalized chronic hypotension, ilure and hypertension. 3/31/15 3:47 PM indicated een admitted with skin tears to right hand and right wrist.		F309 Provide Care/Services For Highest Well Being Criteria 1 Resident #3 discharged on 7/9/2015 Criteria 2 On 7/22/15 100% Audit was conducted of all residents with skin tears by MDS nurses, Assistant Director of Nursing, Staff Facilitator and Director of Nursing, Staff Facilitator and Director of Nursing, Care Plan and Care Guide updated base on findings. 100% of all residents will ha a preventative assessment completed by	ed ve		

Facility ID: 070226

If continuation sheet Page 9 of 30

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345562	B. WING		- (	) 2/2015	
	PROVIDER OR SUPPLIER	0.0002		STREET ADDRESS, CITY, ST	-	JZ/2015	
		EHABILITATION CENTER		IMERCE DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	IN OF CORRECTION TE ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE	
F 309	Set (MDS) indicated cognitively impaired of care. The MDS extensive assistance use, and personal h Progress notes for Resident #3 had su elbow during a trans wheelchair. The nu was resistive to car living and transfers. or plan initiated to p sustaining skin tear On 4/10/15 at 11:59 the treatment nurse Resident #3 ' s righ Resident #3 ' s othe documented Reside The intervention do see if the resident ' adjustment. There indicated the nurse medication. Review of a nursing 11:24 AM indicated s attention an open area. The nurse do area, cleansed the applied a hydrocollo were put into place On 5/5/15, a Flow-s Conditions indicated lower leg, medium s	5 Admission Minimum Data d Resident # 3 was severely d with no behaviors or rejection revealed the resident required ce for transfer, dressing, toilet hygiene. 4/10/15 at 9:32 AM indicated stained a skin tear to his right sfer from bed to the urse documented Resident #3 e during activities of daily . There were no interventions prevent Resident #3 from	F3	<ul> <li>the Staff Facilitator i in-servicing of licens preventative assess quarterly, and as ne interventions based risk residents. All ind immediate intervent Nurse. On 7/16/15, in-serviced by Direc updating Care plan for skin tears.</li> <li>Criteria 3 The Director of Nursing, MDS Nurses will mo admissions, and any care plans and care with interventions.</li> <li>during clinical meeti one week, then weet then monthly for two audits will be review meeting M-F.</li> <li>Criteria 4</li> <li>The Director of Nurse Improvement nurse results to the Execu Improvement Comm will review the result monthly and make r needed for continue area and to determi</li> </ul>	sed nursing staff on ments on admission, eded with on the findings for at cidents will have ions by a License MDS nurses tor of Nursing on for actual and at risk sing, Assistant Staff Facilitator, and onitor all new y incidents to ensure guides are updated This will be completed ng Monday-Friday for kly for one month, o months. Incident red in the daily sing or Quality will report the audit tive Quality nittee. The Committee ts of the audits ecommendations as id compliance in this		

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	· · /	TE SURVEY MPLETED		
				C		
				07/02/2015		
	10	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227				
CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	(X5) COMPLETIC DATE		
healing) applied. The dressing as changed every 3 days and ow-sheet of Non-Ulcer Skin ted Resident #3 had a left shin flap, yellow discoloration, with dges. The nurse noted the n by the wound care specialist loted was a new physician ' s ue the Santyl (a wound product lead tissue) and use medihoney used to promote healing) daily. themt notes for 6/11/15 at 6:57 d and indicated Resident #3 was WCS on 6/10/15 and found the anterior mid shin as improved. ured 1.6 centimeters (cm) x 0.7 crotic (dead) tissue. performed. Medihoney was treatment. Now-sheet of Non-Ulcer Skin a left lower leg skin tear n x 1.9 cm x 0.2 with no exudate , the nurse had written the area id with wound cleanser, patted d and cover with dry protective d as needed until healed. 27 AM, the nurse noted seen by the WCS for skin tear id shin measuring 1.8 cm x 0.9 e skin tear was described as	5					
	R REHABILITATION CENTER TATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL RECTORNATION) Page 10 healing) applied. The dressing as changed every 3 days and ow-sheet of Non-Ulcer Skin ted Resident #3 had a left shin flap, yellow discoloration, with dges. The nurse noted the n by the wound care specialist Noted was a new physician 's ue the Santyl (a wound product lead tissue) and use medihoney t used to promote healing) daily. Attment notes for 6/11/15 at 6:57 d and indicated Resident #3 was WCS on 6/10/15 and found the anterior mid shin as improved. Sured 1.6 centimeters (cm) x 0.7 crotic (dead) tissue. B performed. Medihoney was treatment. Now-sheet of Non-Ulcer Skin a left lower leg skin tear n x 1.9 cm x 0.2 with no exudate to the nurse had written the area ad with wound cleanser, patted d and cover with dry protective d as needed until healed. 27 AM, the nurse noted seen by the WCS for skin tear id shin measuring 1.8 cm x 0.9 e skin tear was described as	A. BULLDING	345562     B. WING       R     STREET ADDRESS, CITY, STATE, ZIP C       ID PROVIDERS PLAN OF COP       COMMERCE INFORMATION)       ID PROVIDERS PLAN OF COP       REHABILITATION CENTER       ITATEMENT OF DEFICIENCIES       ID PROVIDERS PLAN OF COP       COMMERCE INFORMATION)       PRECEDED BOY FULL       REHABILITATION CENTER       ID PROVIDERS PLAN OF COP       COMMERCE MINT HILL, NC 28227       TATEMENT OF DEFICIENCIES       ID PROVIDERS PLAN OF COP       ID PROVIDERS PLAN OF COP       ID PROVIDERS PLAN OF COP       REHABILITATION CENTER       ID PROVIDERS PLAN OF COP       ID PREFIX       CARCEDED BO FULL       REGEDED DE NULL       PREFIX       ID PROVIDERS PLAN OF COP       ID PROVIDENTIALING INFORMA	A. BULUING     07       R     STREET ADDRESS, CITY, STATE, ZIP CODE       REHABILITATION CENTER     10566 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227       TATEMENT OF DEFICIENCIES (CY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)     ID PREFIX TAG     PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       page 10 healing) applied. The dressing as changed every 3 days and Dow-sheet of Non-Ulcer Skin ted Resident #3 had a left shin flap, yellow discoloration, with dges. The nurse noted the n by the wound Care specialist loted was a new physician 's ue the Santyl (a wound product lead tissue) and use medihoney it used to promote healing) daily. thrent notes for 6/11/15 at 6:57 d and indicated Resident #3 was WCS on 6/10/15 and found the anterior mid shin as improved. ured 1.6 centimeters (cm) x 0.7 crotic (dead) tissue. performed. Medihoney was treatment. 'Iow-sheet of Non-Ulcer Skin a left lower leg skin tear n x 1.9 cm x 0.2 with no exudate. , the nurse had written the area d with wound cleanser, patted d and cover with dry protective d as needed until healed. 27 AM, the nurse noted seen by the WCS for skin tear id shin measuring 1.8 cm x 0.9 e skin tear was described as		

If continuation sheet Page 11 of 30

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:			(X3) DA	). 0938-039 TE SURVEY MPLETED	
		345562	A. BUILDI	NG		С	
	PROVIDER OR SUPPLIER	343302	D: 11110	STREET ADDRESS, CITY, STATE, ZIP CC		/02/2015	
		REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 309	observed with an o that was approxima- bed appeared to be Nurse #1 stated the discovered the wou on it " since discov unaware of the orig added the WCS sa Wednesday. The family member at 9:40 AM. She st was the one that di added the open wo 's lower leg as he s pants rose above th was observed. The how the wound had NA #2 was interview The NA stated she day she worked wh week. NA #2 state Resident #3 receive leg, but added it wa to get skin tears. S transferred Residen the path was clear his skin. NA #2 state lower leg skin tear before discovery, w sure the resident has The NA stated instr were found on the o nurse 's station. The did not include infor are at risk for skin to During an interview 2:30 PM, she stated	nent. Resident #3 was pen wound on his left lower leg ately 2.54 cms. The wound 50% to 75% yellow tissue. e resident 's family member and, but the facility had been " very. She stated she was jin of the wound. Nurse #1 w Resident #3 every er was interviewed on 6/30/15 tated another family member scovered the wound. She bund was seen on Resident #3 sat in the wheelchair. His ne wound and that 's when it family member had no idea d occurred. wed on 6/30/15 at 1:21 PM. cared for Resident #3 each hich was usually 5 times per d she was unaware how ed the skin tear on his lower as not unusual for the resident She added when she nt #3 she tried to make sure to avoid having any object hit ted she was off duty when the was found. She added the day when she worked, she was ad no skin tear on his leg. fuctions for caring for residents care guides located at the The care guide, the NA stated, rmation about residents who		09			

STATEMENT	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DA	). 0938-039 TE SURVEY MPLETED	
	U CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	IG	C		
		345562	B. WING _		07/02/2015		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL			
CLEAR (	REEK NURSING & F	REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 309	Continued From pa	age 12	F 30	09			
	She added it was the	he responsibility of the MDS					
	nurse to care plan	skin tears. The nurse was					
		kin tear on Resident #3 ' s skin					
	had occurred. NA #3 was interview	wed on 7/1/15 at 10:03 AM.					
		how the left lower leg skin tear					
	had occurred.	C C					
		eld with the Director of Nursing					
		urse #1 on 7/1/15 at 1:30 PM. ne expected Resident #3 ' s					
:		dressed on the care plan. The					
		care plan and stated she did					
		identifying skin tears as a					
		ent #3, did not identify					
		in tear prevention and did not t ' s current wound identified					
		n tear. The DON reviewed the					
		ed to be used by the NAs for					
		s and stated the resident's risk					
		terventions for skin tear					
		i identified on the care guides e MDS nurse stated she had					
		/ the skin tear on the left shin					
		prevent skin tears had not					
		Resident #3 ' s care plan or					
	care guide.	······································					
		ew with Nurse #2 was I5 at 10:47 AM. The nurse					
		had written the note dated					
		V about the open area on					
	Resident #3 ' s left	shin. Nurse #2 stated she had					
		he area prior to that day. The					
		ad observed the resident's					
		cing an antibiotic ointment on nd asked what she was doing.					
		he had not received reports					
	about the skin tear	to Resident 3 's left shin from					
		port. The nurse stated on first					
	observation the wo	ound was a small red area that	1			1	

If continuation sheet Page 13 of 30

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		<u>NO. 0938-039</u> DATE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
					С
		345562	B. WING _		07/02/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CLEAR C	REEK NURSING & R	EHABILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE
F 309	Continued From pa	ige 13	F 30	9	
	reported the area to #2 stated she had o	Nurse #3 added she had o the treatment nurse. Nurse questioned NA #2 and the NA ea was not there during the			
F 314 SS=D	483.25(c) TREATM PREVENT/HEAL P	IENT/SVCS TO RESSURE SORES	F 31	4	7/27/15
	who enters the faci does not develop p individual's clinical they were unavoida pressure sores reco	r must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and from developing.			
	by:	NT is not met as evidenced tions, interviews with staff and		F214	
	record review, the f assess a pressure residents (Resident use care planned p 1 of 2 sampled resi with pressure ulcer Findings included: Resident #1 was ac	acility failed to correctly ulcer for 1 of 2 sampled t #1) and failed to consistently ressure ulcer interventions for dents (Resident #1) reviewed		F314 Treatment/Services to Prevent/Heal Pressure Sores Criteria 1 Heels floated for resident #1. Treatmen nurse watched Orientation Video on Wound Care. Treatment nurse in-service by Nurse Consultant on Assessment, Documentation and Staging of Wounds	ced
	history of fall, generaphasia. The 4/29/15 Nursin Assessment indicar had bruising on her scab on the back o	ralized muscle weakness and g Admission and Re-entry ted on admission the resident right lower extremity, a small f her head, old bruising on the red birth mark on her chin.		Criteria 2 On 7/8/15 the Staff facilitator initiated a 100% in-servicing of all nursing staff or following Care Guides, how to properly float heels, and how to correctly apply bunny boots. Treatment nurses watche Wound Care Video and in-serviced by	1

Facility ID: 070226

If continuation sheet Page 14 of 30

	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUT	TIPLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG	`́сом	PLETED
		345562	B. WING _		07/0	C D2/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0.77	
CLEAR	CREEK NURSING & R	EHABILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 14	F 3 ⁻	14		
	There was no docu right or left heel or t A late entry nursing at 3:50 PM, with a c AM indicated Resid facility with blisters to which skin prep wo was also a fluid fille measuring 0.2 cent which skin prep wo A 5/3/15 at 2:37 AW indicated Resident heels. A physician's order, Resident #1 ' s hee bed. The 5/5/15 Admissi indicated Resident memory with sever daily decision makin documented as occ The resident require bed mobility, transfe personal hygiene. with 3-Stage II pres on admission. On 5/7/15 a Skin/W it was to continue th right heel blister me x 4.2 cm x 0 cm an measured 5.9 cm x dark red/purple disc Staff received a phy 5/11/15 that indicate applied to the residu skin. The Care Area Asse	mentation of blisters on the the ischium. progress note, dated 4/29/15 created date of 5/6/15 at 9:06 lent #1 was admitted to the to the right heel and left heel would be applied daily. There ed blister to the right ischium imeters (cm) x 0.1 (cm) to uld be applied daily. 1, Skin/Wound Treatment Note #1 had blisters noted to both dated 5/4/15, indicated Is were to be floated while in ion Minimum Data Set (MDS) #1 had short and long term ely impaired cognitive skills for ng. Rejection of care was curring 1 to 3 days per week. ed extensive assistance with er, eating, toilet use and Resident #1 was identified sure ulcers that were present found Treatment noted stated he note of 4/29/15. Resident's easured 6.1 centimeters (cms) d the left heel blister 4.0 cm x 0 cm with red and		<ul> <li>Nurse Consultant on completing the assessments, documentation, and of wounds. License nurses will Ensand monitor that interventions are place.</li> <li>Criteria 3         The Director of Nursing, Assistant Director of Nursing, Staff Facilitato MDS Nurses will monitor all new admissions, and any incidents to e proper assessments, documentatis staging of wounds are correct, also plans and care guides are being u and followed. This will be complet during clinical meeting Monday-Fri one week, then weekly for one mot then monthly for two months. Direct Nursing and Assistant Director of N DON will monitor 5 wounds per weeks then 5 wounds monthly for months then quarterly. any negative findings will be corrected immediate Nurses educated. Incident audits wereviewed and monitored in the dail meeting M-F.     </li> <li>Criteria 4         The Director of Nursing or Quality Improvement Nurse will report the results to the Executive Quality Improvement Committee. The con will review the results of the audits monthly and make recommendation needed for continued compliance farea and to determine the need for or/frequency of continued QI monitor of continued QI monitor of the provement QI monitor AI moni</li></ul>	staging sure in r, and ensure on, and o care pdated ed day for nth, ctor of Nursing eek for 4 4 re tely and vill be y audit nmittee ons as in this r and	

STATEMENT	OF DEFICIENCIES OF CORRECTION	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	. ,		(X3) DA	D. 0938-039 TE SURVEY MPLETED C
		345562	B. WING		07/02/2015	
NAME OF	PROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CLEAR	CREEK NURSING & R	EHABILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIV MINT HILL, NC 28227	/E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 314	the right ischium. plan the pressure u documented staff w pressure relieving of repositioning ". Review of a 5/14/19 Skin Condition reve left heel measuring red tissue and gran documented a xero dressing) and dry d nurse described the Review of the resid 5/14/15, indicated t breakdown or deve ulcers. The goal of worsening was to b appropriate pressure the skin and notifyin changes and placin relieving products s mattress and chair On 5/20/15, the Wo assessed Resident Stage II pressure w and an unstageable ulcer to the left pos resident was also fo pressure ulcer of th pressure ulcer and ulcer. The Non-Ulcer Skin 5/27/15 indicated o	age 15 ad the right and left heel and A decision was made to care licers. The MDS nurse were to "ensure appropriate devices in place during 5 Flow-sheet of Non-Ulcer ealed a blister was noted to the 1.4 cm x 1.5 cm with pink and pulation tissue. The nurse oform (a type of non-adhesive ressing was applied. The e blister as blood filled. ent 's care plan, reviewed on he resident was at risk for skin lopment of further pressure f the current wound not be attained through assuring re relieving devices, inspecting ng the nurse of abnormal ng Resident #1 on pressure such as a pressure relieving cushion as appropriate. bund Care Specialist (WCS) #1 and found she had a yound of the left posterior heel e (due to necrosis) pressure terior, lateral heel. The bund to have a Stage II he coccyx and a Stage II he left lateral hip. The WCS initial evaluation of the coccyx the left, lateral hip pressure	F 314			

Facility ID: 070226

If continuation sheet Page 16 of 30

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		TE SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	со	MPLETED	
		345562	B. WING _	B. WING		C 07/02/2015	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP		102/2010	
CLEAR C	REEK NURSING & R	EHABILITATION CENTER		10506 CLEAR CREEK COMMERC MINT HILL, NC 28227	E DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIC DATE	
F 314	Continued From pa	ge 16 oduct for treating wounds) to	F 31	14			
	be applied. The 5/27/15 WCS I	Evaluation of Resident #1					
	posterior heel and a of the right, posterio pressure ulcer was	an unstageable pressure ulcer or, lateral heel. The coccyx not staged as unstageable					
	pressure ulcer of th Assessment and Pl						
	she was in bed and Review of the Non-	ing the resident 's heels when off-loading the wound. Ulcer Skin Condition flow					
	cm with granulation indicates healing).	blister right heel 0.7 cm x 0.9 tissue (a type of tissue that					
	5/27/15 indicated R hip blister measurin						
	to float heels had b	ord (MAR) indicated an entry een added to the MAR.					
	Flow-Sheet indicate 100% granulation.	5 Non-Ulcer Skin Condition ed Resident #1 ' s left heel had	t				
	Stage III pressure u an unstageable pre	on, dated 6/3/15, indicated a llcer of the left posterior heel, ssure ulcer of the coccyx, and	1				
	a Stage II pressure that had resolved o Review of a 6/3/15						
	to the right heel and by the WCS.	nent Note indicated the blister d left lateral hip were resolved					
	The Physician's tele indicated Resident	ephone order, dated 6/8/15, #1 ' s heels should be floated. of the WCS Evaluation					

Facility ID: 070226

If continuation sheet Page 17 of 30

		& MEDICAID SERVICES				. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TPLE CONSTRUCTION		E SURVEY
		345562	B. WING _			C / <b>02/2015</b>
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR (	CREEK NURSING & R	EHABILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIV MINT HILL, NC 28227	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 314	improved A Skin/Wound Trea 9:11 PM indicated a the left posterior he measuring 0.2 cm > 100% granulation ti Review of the 6/17/ a Stage III pressure heel with a resolved pressure wound of unstageable deep t ischium. The WCS evaluation of the rig Physician's telephot the right ischium wo foam dressing daily wound be off loaded area). Review of a 6/19/15 revealed the Stage had resolved. The deep tissue injury o	tre ulcer of the coccyx that had tre ulcer of the coccyx that had tre treat note, dated 6/11/15, at Stage III pressure ulcer to el presented as improved 0.5 cm x unmeasurable with ssue. 15 WCS Evaluation revealed e ulcer of the left, posterior date of 6/17/15, a Stage IV the coccyx and an issue injury of the right noted this was his initial	F 3 ⁻	14		
	ishchial wound (not admitted with the w of 6/17/15 indicated wound in the facility The Resident Care nursing assistants ( with a date of 6/19/ heels should be off A wound observation at 11:20 AM. The r approximately the s tissue in the wound area was cleansed dressing applied. T	e indicated resident was ound, although the WCS note i twas a new onset pressure ). Guide (a guide to direct NA) in caring for residents) 15, indicated the resident's				

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	) <u>. 0938-039</u> TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED
		345562	B. WING		C 07/02/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		/02/2015
		REHABILITATION CENTER		10506 CLEAR CREEK COMMERCE DR MINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 314	Continued From pa	age 18	F 3 ²	14		
		healed. The sacral wound was	10	17		
		s time since the treatment was				
		esident's pain. The resident'				
	s heels were not flo					
		bed, but not applied correctly				
		t ' s heels directly in contact				
	with the bed.	rse that initially identified the				
		and the heels that assessed				
		-pressure areas was				
		rview since she no longer was				
	employed by the fa					
		with NA #1 and Nurse #1 on				
		stated the admitting nurse was				
		nission skin assessments.				
		ea of skin impairment was ound protocol was followed				
		e to the treatment nurse. The				
		the WCS was responsible for				
		ents and documentation. The				
		ound was found in house,				
		hered from the staff and the				
		am handles the incident. NA #1				
		's ischial pressure ulcer was ek. Prior to that, she stated				
		The NA stated she was a NA II				
		und care to residents and that				
		the area had been red on the				
	resident ' s ischium	<ol> <li>The NA stated she</li> </ol>				
		assigned to Resident #1 to turn				
		The nurse stated pressure				
		in place for Resident #1				
		ttress, limited time sitting up, essing on the left hip and turn				
		was standard for all residents				
		e. The nurse stated all				
		esponsible to make sure				
	residents had their	bunny boots on and their feet				
	were floated. Sh	e stated there was no order on	1			

Facility ID: 070226

If continuation sheet Page 19 of 30

		AND HUMAN SERVICES				FOR	ED: 08/10/2015 RM APPROVED O. 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		345562	B. WING	;		C	C 7/02/2015
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP C		
					10506 CLEAR CREEK COMMERCE	DRIVE	
CLEAR	SREEK NURSING & R	EHABILITATION CENTER			MINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	the resident 's trea An interview was he at 2:23 PM. She st worked with Reside the responsibility of pressure ulcer prev placed, including for were responsible for removed during pro- stated when heels kept from touching included the pillow Interventions for pri- include pillows for pri- not get out of bed ji bunny boots. The were used for a res- the treatment book at this time. The nu- resident 's heels with the pillow that supp An observation was Resident #1 was ly was on and one was bed with no pillows NA #4, who was as on 7/1/15 was inter She stated that floa heels elevated and against anything. The moved her feet a low worked with the res- fault there had bee feet. This morning the pillow under Re- assist the resident to she did not know wi under the resident to the resident to the resident to the resident the resident to the resident the resident to the resident the resident to worked with the res-	tment sheet to her heels. eld with Nurse #3 on 6/30/15 cated when she worked, she ent #1. Nurse #3 stated it was all staff to make sure vention interventions were bating heels. She stated NAs or replacing interventions ovision of care. Nurse #3 were floated, the heels were any surface. She added this on which the legs rested. essure ulcer prevention positioning, turn and position, ust turn from side to side and nurse stated if bunny boots sident they should be listed in . An observation was made urse acknowledged the rere not floated, but laying on		314	4		

Facility ID: 070226

If continuation sheet Page 20 of 30

PRINTED: 08/10/2015

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			TE SURVEY MPLETED	
		345562	B. WING		C 07/02/2015		
NAME OF	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
CLEAR	CREEK NURSING & F	REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE	
F 314	morning. MDS Nurse #2 and were interviewed of MDS nurse stated had pressure ulcer indicated blisters, w Stage II pressure ulcer indicated blisters, w stated the nurse the note and had caller ulcers, non-pressu the facility. The DC of the heel wounds inaccurate. The he coded under press wound status, non- not made a different by Resident #1. An interview was h 7/1/15 at 1:10 PM. purpose of the card to maintain function place to fix the pro- care of the resident term " making sure releasing devices " mattresses, bunny MDS nurse stated responsible to mak placed and applied	age 20 d the Director of Nursing (DON) on 7/1/15 at 12:01 PM. The she had coded Resident #1 's because the assessment which would be considered ulcers. She based this rse's notes dated 4/29/15 and Non-Pressure Ulcer Wound the DON stated the expectation cumentation to be completed d not a week later. The DON at documented the 4/29/15 d Resident #1's pressure re ulcers, no longer worked for ON stated the documentation s, starting on 5/14/15 was eel wounds should have been sure. The DON stated the -pressure versus pressure had nce in the treatment received eld with MDS Nurse #1 on The MDS nurse stated the e was to put something in place n or to put interventions in blems. The care plan directed it. The MDS nurse stated the e appropriate pressure ' were in placed covered air boots and floating heels. The the nurse and the NA were as sure all interventions were in a correctly. Floating heels nould not be resting on the bed	F 314				

Facility ID: 070226

If continuation sheet Page 21 of 30

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/10/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	_	(X3) DATE COM	E SURVEY PLETED
		345562	B. WING _				C 02/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
CLEAR C	REEK NURSING & R	EHABILITATION CENTER		10506 CLEAR CREEK CO MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TVE ACTION SHOULD CED TO THE APPROPI FICIENCY)	BE	(X5) COMPLETION DATE
F 314 F 323 SS=E	resident. The nurse for all wounds prese admitting nurse or t hours of admission. Resident #1 had a d where she currently arms and legs and a Nurse #4 added if F ulcer on admission, that pressure ulcer. remember if the res admission. The nur nurse at the time as day, but added she treatment nurse fou treatment nurse fou treatment nurse of 483.25(h) FREE OF HAZARDS/SUPER ¹ The facility must en environment remain as is possible; and d adequate supervisio prevent accidents.	ission assessment for this e added the expectation was ent to be documented by the he treatment nurse within 24 . On admission, she added, dark area on her sacrum has a wound, bruising on her a scab on top of her head. Resident #1 had a pressure she should have documented The nurse was unable to ident had pressure ulcers on urse stated the treatment essessed the resident the next was unaware of what the and. Nurse #4 added that longer worked for the facility. FACCIDENT	F 3		on/Devices		7/27/15
	severely cognitively facility failed to eval put in place after m	impaired residents. The uate interventions that were ultiple falls of 2 of 3 sampled #4 and Resident #3)		Criteria 1 Care plan and care MDS Nurse to incl Resident #4 on 7/2	e guide updated ude fall intervent		

Facility ID: 070226

If continuation sheet Page 22 of 30

	OF DEFICIENCIES	K MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY	
	of connection	IDENTIFICATION NOWBER.	A. BUILDIN	IG		C	
		345562	B. WING			02/2015	
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	ZIP CODE		
CLEAR (	CREEK NURSING & R	REHABILITATION CENTER		10506 CLEAR CREEK COMMER MINT HILL, NC 28227	RCE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F 323	Continued From pa reviewed for falls.	age 22	F 32	23 Resident #3 discharged	on 7/0/2015		
	diagnoses that inclu generalized muscle osteoarthritis, rheu coordination and hy The Admission Min 2/13/15, revealed F intact. She was co assistance with tran for ambulation in he unit. The MDS also only able to stabiliz during transition an identified as having Review of nurse 's at 4:37 AM, revealed her knees between sustained a small s documented Resid on the side of the b bothering her while added she must ha documented she re Education for the re	s admitted on 2/6/15 with uded personal history of fall, e weakness, diabetes, matoid arthritis, lack of ypertension. imum Data Set (MDS), dated Resident #4 was cognitively oded as requiring limited nsfers, extensive assistance er room and locomotion on the o indicated Resident #4 was e with human assistance id walking. Resident #4 was falls since her admission. progress notes, dated 4/14/15 ed Resident #4 was found on wheelchair and the bed. She skin tear. The nurse ent #4 stated she was sitting bed because her knees were holding on to wheelchair and twe fallen asleep. The nurse emoved the wheelchair. esident and family on entions, to include lying down		Criteria 2 100% Audit of all residen risk evaluation complete license nurses, and care guide updated based on 7/22/15. On 7/16/15, the initiated a 100% in servio nursing staff on how to o assessments which are upon admission and qua needed, with intervention findings. All incidents wi interventions by license 7/16/15, MDS nurses in- Director of Nursing on up Plans and Care Guides interventions after each Criteria 3 The Director of Nursing, Staff MDS Nurses will monito admissions to identify wi falls and skin impairmen incidents to ensure care	d on 07/22/15 by e plan and care findings by e Staff Facilitator cing of licensed complete falls to be completed arterly and as ns based on the ill have immediate Nurse. On serviced by pdating Care to include new incident. Assistant f Facilitator, and r all new ho are at risk for it, and any		
	for support, were a Nurse 's progress PM indicated Resid with no injuries. The resident attempted unassisted after be assistance. The ca added included free assistance and to e system after each r	ng the wheelchair when used dded to the care plan. notes dated 4/21/15 at 7:53 dent #4 had 2 falls that shift ne nurse documented the to go to the bathroom ing reminded to ring for staff are plan revealed interventions quent reminders to call for empty the urine collection meal were added. ty ' s fall log indicated Resident		guides are updated with interventions. This will b during clinical meeting M one week, then weekly f then monthly for two mo audits will be reviewed in meeting M-F. Criteria 4 The Director of Nursing Improvement Nurse will results to the Executive	be completed Monday-Friday for for one month, nths. Incidents in the daily or Quality report the audit		

Facility ID: 070226

If continuation sheet Page 23 of 30

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
IND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG		
		345562	B. WING		C 07/02/2015	
NAME OF I	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR (	CREEK NURSING & F	REHABILITATION CENTER		VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 323	Continued From pa	age 23 23/15. There was no progress	F 32	13 Improvement Committee. The		
	note that documen care plan was revis monitor for routine The resident ' s car 4/23/15, indicated t supervision only. L resident was identi Included for the nu instructions to emp meal, encourage th assistance (based items in reach, nor ambulation. The nurse ' s progr and dated 4/24/15 heard Resident 4 ' Resident #4 was for bathroom floor. Th was assisted back in common area. S minute checks wer document a time fr On 5/6/15, Resider risk using the fall ri Resident #4 ' s Qua (MDS), dated 5/15/	ted the fall. On 4/23/15, the sed and staff were instructed to needs. re guide, with a print date of the resident was to walk with Jnder Special Precautions, the fied with the word "FALLS". rsing assistant 's use was the ty the ostomy bag after each he resident to call for on cognition), keep personal h-skid footwear and supervised ress notes, written by Nurse #2 at 6:15 PM, indicated staff s call bell at 4:45 PM. bund sitting on her buttocks on he nurse noted the resident to her wheelchair and placed She also documented 15 e initiated. The nurse did not ame for the 15 minute checks. ht #4 was identified as a fall		will review the results of the au monthly and make recommend needed for continued complian area and to determine the need or/frequency of continued QI m	dits ations as ce in this I for and	
	limited assistance the room, supervis the corridor and lim locomotion was red off the unit. The M requiring extensive personal hygiene. identified with falls	quired for transfer, bed mobility, was required when walking in ion was needed for walking in nited assistance with quired with locomotion on and DS identified Resident #4 as assistance with toilet use and The resident was also since admission or the prior umbered 2 or more with no				

CENTERS FOR MEDICARE & MEDICAID SERVICES         TATEMENT OF DEFICIENCIES         ND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345562		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C 07/02/2015	
		CLEAR	CREEK NURSING & F	REHABILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 323	Review of nurse 's revealed during cha notified Resident # documented the re side of the bed faci Documentation rev bed while trying to nurse documented were too slippery to assisted to wheelch added on the care Nurse 's notes dat indicated staff repo floor. The nurse do resident 's room an face down on the fl the resident stated bottoms. Review of plan revealed no ne On 6/1/15 at 1:28 F therapy had notified was found sitting of resident stated she urinary collection b stood up and lost h documented she sp importance of pullir she needed to go to On 6/2/15, the care included an interve to use a urinal to en system. Nurse 's notes for the nurse was called the nursing assista observed sitting in buttocks against th	notes for 5/29/15 at 9:28 AM, ange of shift, the nurses were 4 was on the floor. The nurse sident was sitting on the left ng the nightstand. ealed the resident rolled out of put her slippers on. The Resident # 4 stated her socks o stand up. Resident #4 was nair. No interventions were plan to prevent further falls. ed 5/30/15 at 5:05 AM rted Resident #4 was on the ocumented she entered the nd found Resident #4 lying oor. The nurse documented she was trying to changed her f progress notes and the care ew interventions were initiated. PM, nurse 's notes revealed d nursing staff that Resident #4 n the bathroom floor. The e was trying to empty her ag, reached for the railing, er balance. The nurse boke to resident about the ng the emergency bell when o the bathroom. e plan was revised and ntion to educate Resident #4 mpty the urinary collection 6/12/15 at 7:22 PM indicated ed to Resident #4 's room by nt (NA). Resident #4 was the bathroom floor with her e wall facing the toilet. The Resident #4 told her she was	F 32	23		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	0MB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
		A. BUILDI	NG	CO		
		B. WING		07	/02/2015	
NAME OF PROVIDER OR SUPPLIER			· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP COD		
CLEAR	CREEK NURSING & F	REHABILITATION CENTER		10506 CLEAR CREEK COMMERCE DR MINT HILL, NC 28227	VE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 323	Continued From pa	-	F 3	23		
	at 7:50 PM the nurse for help. The nurse resident holding to half way off the been nurse documented the floor. Resident call light. No inter- care plan. NA #2 was interview She stated she wor on the days she was added she had no had been identified was unaware the re 30 days. NA #3 worked with medication aide. So AM. She stated in the fall prevention p the resident as a fa guide (a guide used care). If a resident check on the resident the resident in com possible. The NA is or bracelets used to risk. The NA identii but stated she was fallen in the past 30	4 PM, nurse 's notes indicated se heard Resident #4 calling e documented she found the the side rail with her buttocks d with feet on the floor. The she assisted the resident to : #4 was encouraged to use the ventions were added to the wed on 6/30/15 at 1:21 PM. rked full time with Resident #4 as scheduled to work. The NA residents assigned to her that as a high fall risk. The NA esident had fallen in the past Resident #4 on 7/1/15 as a She was interviewed at 10:03 terventions for residents on orogram included identifying all risk on the resident care d by the NAs for provision of was a fall risk staff knew to ent more frequently and keep imon areas as much as stated there were no symbols o identify residents as a fall fied Resident #4 as a fall risk, unsure if the resident had 0 days. The NA added if a formation was relayed to the				
	interviewed. The I about resident falls morning departmer	Ange of shift report. PM, MDS Nurse #1 was MDS nurse stated information was relayed during the ht head meetings. She added Resident #4 had fallen on				

Facility ID: 070226

If continuation sheet Page 26 of 30

		AND HUMAN SERVICES				FORM	08/10/2015 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
345562		B. WING			C 07/02/2015			
NAME OF F	PROVIDER OR SUPPLIER	1	1	ę	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CLEAR C	REEK NURSING & R	EHABILITATION CENTER			10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 323	at 10:50 AM. She s for 4/24/15 at 6:15 resident fell, she wa placed depended o stated the 15 minut note was a neurolo resident had an un- stated she had com 15 minutes for 1 ho 1 hour then every h hours until the neur There were no othe every 15 minute ch hour. A telephone intervie 7/2/15 at 3:03 PM. remember the spec 6/12/15 fall. She ac the bathroom by he many times to ask stated most of the t oriented, but had fr which increased he Nurse #5 stated mu for Resident #4 incl place the resident i increased observat notes failed to reve observations. 2. Resident #3 wa diagnoses of difficu generalized muscle hypotension, hyper failure. An Admission Minir	nge 26 viewed via telephone on 7/2/15 stated she had written the note PM. She stated when a as to assess. Interventions in the resident. The nurse re checks she referred to in the gical (neuro) check since the witnessed fall. Nurse #2 npleted the neuro checks every our, then every 30 minutes for nour for 4 hours, then every 4 rological check sheet was full. er interventions placed and the eck ended at the end of 1 ew was held with Nurse #5 on She stated she did not cifics about the resident's dded Resident #4 tried to go to erself and has been educated for assistance. The nurse time the resident was alert and equent urinary tract infections er confusion and her falls. Ultiple intervention were used luding 1 to 1 observation or to n a common area for ions. Review of the nurse ' s al documentation of 1 to 1 es admitted on 3/31/15 with hity walking, atrial fibrillation, e weakness, chronic tension and congestive heart mum Data Set (MDS), dated e resident was severely	F	323				

PRINTED: 08/10/2015 FORM APPROVED

STATEMEN	CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED	
345562		B. WING		C 07/02/2015			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
		REHABILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 323	cognitively impaired assistance for trans and personal hygie Resident #3 was mo one plane to anoth coded as having no Nurse 's notes dat revealed Resident nurse noted upon e was found to be sit wheelchair. She m floor back to his be Review of nurse 's revealed the reside and his call light wa Nurse 's notes for the nurse had beer assistant (NA) that in the floor in front intervention was to The care plan for F 4/28/15 indicated th The goal of not sus the next review wa during transfer and position (4/2/15), re (4/18/15), fall risk p reach and answer frequent reminders assistance before o On 5/20/15 at 9:22 nurse 's notes that sitting on the floor i A 6/28/15 Quarterly as severely cogniti- extensive assistant no falls since the p NA #2 was intervie	d. He required extensive sfer, bed mobility, toilet use ene. The MDS indicated of steady during transition from er and during walking. He was o falls since admission. ed 4/15/15 at 4:00 PM, #3 yelled out for help. The entering the room, Resident #3 ting on the floor in front of his oted she assisted him from the ed. a notes for 4/16/15 at 6:13 PM ent ' s bed was in low position as in place. 4/17/15 at 8:39 PM indicated n notified by the nursing Resident #3 was found sitting of his wheelchair. The monitor. Resident #3, last reviewed on he resident was at risk for falls. staining serious injury through s to be attained by assisting mobility (4/2/15), bed in low ehabilitation therapy referral protocol (4/2/15), call light in timely (4/2/15) and provide a to resident to call for getting up (4/15/15). PM the nurse documented in t Resident #3 was observed in front of his wheelchair. y MDS identified the resident vely impaired, requiring ce with transfer and as having	F 32				

Facility ID: 070226

If continuation sheet Page 28 of 30

CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES         AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA         IDENTIFICATION NUMBER:         345562			TIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED		
		B. WING			C 07/02/2015	
NAME OF PROVIDER OR SUPPLIER CLEAR CREEK NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	D BE	(X5) COMPLETIO DATE
F 323	day she was sched she had no residen were identified as a Resident #3. An observation was Resident #3 was in raised. The call be the cord outlet appr right and back of th interviewed at this to to put the call bell in NAS #3 was intervi The NA stated if a r was identified on th notified the NAs to resident and to kee when possible. NA symbols were not u were identified as a was not sure if Res 30 days. She adde information about th during the change of An interview was he (DON) and the MDS The MDS nurse reviewed acknowledged he h cognitively impaired #1 stated educatior intervention for Res cognitive status. T should be revised w	uled to work. NA #2 stated ts on her assignment that a high fall risk, including a made on 6/30/15 at 8:05 PM. bed with the half side rails Il was hanging on the wall over roximately 3 to 4 feet to the re resident. NA #2 was time and stated she forgotten n reach. ewed on 7/1/15 at 10:03 AM. resident was a high fall risk it re resident care guide. This make frequent rounds on the p them in common areas A #3 added bracelets or used to identify residents that a fall risk. The NA stated she ident #3 had fallen in the past ed if a resident fell, the he fall was relayed to NAs	F 32	23		

Facility ID: 070226

If continuation sheet Page 29 of 30

CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA         (X2) MULTIPLE CONSTRUCTION           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:         A PLUE DINC	0	<u>MB NO.</u>		
	(X2) MULTIPLE CONSTRUCTION			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		COMPLETED C		
345562 B. WING		07/02/2015		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIF				
CLEAR CREEK NURSING & REHABILITATION CENTER 10506 CLEAR CREEK COMMERCE MINT HILL, NC 28227				
(X4) IDSUMMARY STATEMENT OF DEFICIENCIESIDPROVIDER'S PLAN OF CPREFIX(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGPREFIX(EACH CORRECTIVE ACTIV TAG(EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH 	ON SHOULD	D BE COMPLÉTION		
F 323 Continued From page 29 had no explanation why the care plan had not been revised.	<u>}</u>			

Facility ID: 070226

PRINTED: 08/10/2015