	-	ID HUMAN SERVICES					MAPPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u> 0938-0391</u>
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	COM	E SURVEY PLETED
		345562	B. WING				C / 31/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				10	0506 CLEAR CREEK COMMERCE DRIVE		
CLEAR CI	REEK NURSING & REHA	BILITATION CENTER		М	INT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		FO	000			
	1. 483.10 (F580) at	J.					
	Resident #1 began to	began on 05/11/18 when exhibit right side facial					
	not assess the reside	n and drooling. Nurse #1 did nt's change in condition and ort the change in condition to					
	her medical provider	5					
	5:53 PM when the fac implemented an acce	cility provided and					
		iance at a lower scope and					
	more than minimal ha	tual harm with potential for arm that is not Immediate e education and ensure					
	monitoring systems p	ut into place for reporting a condition were effective.					
	2. 483.25 (F684) at J	J					
		began on 05/11/18 when exhibit signs and symptoms					
	side facial droop, and	led slurred speech, right I drooling. Nurse #1 was					
	#1 was exhibiting slui	aff and visitors that Resident rred speech, right sided					
	Resident #1. Immedia	bling and did not assess ate jeopardy was removed					
	and implemented an	M when the facility provided acceptable allegation of emoval. The facility remains					
	out of compliance at a	a lower scope and severity n with potential for more					
	than minimal harm th	-					
		ut into place for assessing a					
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

Electronically Signed

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.

06/22/2018

	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/02/201 APPROVE . 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED C 05/31/2018		
		345562	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	•		
CLEAR CI	REEK NURSING & REHA	BILITATION 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 000	Continued From page resident with a chang	e 1 e in condition are effective.	F 000				
	A revisit was conduct 05/31/18 and the faci compliance. Event IC	lity remains out of					
	facility's follow-up and	was conducted as part of the d complaint investigation to 05/31/18. Event ID#					
F 580 SS=J	Notify of Changes (In CFR(s): 483.10(g)(14	jury/Decline/Room, etc.) ł)(i)-(iv)(15)	F 580			6/29/18	
	consult with the resid consistent with his or representative(s) whe (A) An accident involv	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring					
	(B) A significant chan mental, or psychosod deterioration in health status in either life-the clinical complications	ge in the resident's physical, ial status (that is, a n, mental, or psychosocial reatening conditions or					
	a need to discontinue treatment due to adve commence a new for (D) A decision to tran resident from the faci	e an existing form of erse consequences, or to m of treatment); or sfer or discharge the					
	(14)(i) of this section, all pertinent information	fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the					

Facility ID: 070226

If continuation sheet Page 2 of 37

			PRINTED: 01/02/2019 FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
345562	B. WING		05/31/2018
	•	STREET ADDRESS, CITY, STATE, ZI	IP CODE
BILITATION CENTER		10506 CLEAR CREEK COMMERC	E DRIVE
		MINT HILL, NC 28227	
Y MUST BE PRECEDED BY FULL	ID PREFIZ TAG	X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE
also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations - is not met as evidenced ns, record reviews, staff, e Practitioner and Medical facility failed to notify a e party and Medical Doctor an having facial droop, rooling which resulted in a so failed to notify a resident's an antibiotic which was hary tract infection (UTI) for 1 ed for change in condition	F	Clear Creek Nursing an acknowledges receipt of Deficiencies and propos Correction to the extent of findings is factually co to maintain compliance of rules and provisions of of residents. The Plan of C submitted as a written al compliance. Clear Creek Rehab response to this Deficiencies does not de with the Statement of Deficiencies does not defined and the statement of Deficiencies does not defined with the Statement of Deficiencies does not defined and the st	f the Statement of ses this Plan of that the summary prrect and in order with applicable quality of care of correction is llegation of k Nursing and Statement of enote agreement eficiencies nor
	IDENTIFICATION NUMBER:	MEDICAID SERVICES (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 345562 B. WING ABILITATION CENTER ID PREFI ISC IDENTIFYING INFORMATION) ID PREFI TAG also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph the record and periodically mailing and email) and resident Fill cosite distinct part. A facility istinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations T is not met as evidenced ID on so failed to notify a e party and Medical facility failed to notify a e party and Medical Doctor an natibiotic which was hary tract infection (UTI) for 1 ed for change in condition	MEDICAID SERVICES (x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 345562 B. WING STREET ADDRESS, CITY, STATE, ZI 19566 CLEAR CREEK COMMERC MINT HILL, NC 28227 ABILITATION CENTER ABILITATION CENTER ID PROVIDER'S PLAN (EAC CORRECTIVE, VILL USC IDENTIFYING INFORMATION) PROVIDER'S PLAN (EAC CORRECTIVE, CORRECTIVE, CORSS-REFERENCED I DEFICI SC IDENTIFYING INFORMATION) PROVIDER'S PLAN (EAC CORRECTIVE, CORSS-REFERENCED I DEFICI DEFICI SC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN (EAC CORRECTIVE, CORSS-REFERENCED I DEFICI SC IDENTIFYING INFORMATION) PROVIDER'S PLAN (EAC CORRECTIVE, CORSS-REFERENCED I DEFICI DEFICI SC IDENTIFYING INFORMATION) PROVIDER'S PLAN (EAC CORRECTIVE, CORSS-REFERENCED I DEFICI SC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN (EAC CORRECTIVE, CORSS-REFERENCED I DEFICI SC IDENTIFYING INFORMATION) ID STREET ADDRESS, CITY, STATE, ZI 19566 CLEAR CREEK COMMERC MINT HILL, NC 28227 ID PROVIDER'S PLAN (EAC CORSS-REFERENCED I DEFICI TAG ID STREET ADDRESS, CITY, STATE, ZI 19566 CLEAR CREEK COMMERC MINT HILL, NC 28227 ID STREET ADDRESS, CITY, STATE, ZI 19566 CLEAR CREEK COMMERC MINT HILL, NC 28227 ID STREET ADDRESS, CITY, STATE, ZI 19566 CLEAR CREEK CORSTENDED SC I

Facility ID: 070226

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/02/2019 MAPPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345562	B. WING			05	C 5/31/2018
NAME OF PI	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				10	0506 CLEAR CREEK COMMERCE DRIVE		
CLEAR CH	REEK NURSING & REHA	ABILITATION CENTER		м	IINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580		h and drooling. Nurse #1 did	F	580	deficiency is accurate. Further, Clear		
	not assess the reside	ent's change in condition and			Creek Nursing and Rehab reserves th	ie	
		ort the change in condition to			right to refute any of the deficiencies of	on	
	her medical provider				this Statement of Deficiencies through	ı	
		was removed on 05/31/18 at			Informal Dispute Resolution, formal		
	5:53 PM when the fac				appeal procedure and/or any other		
	implemented an acce				administrative or legal proceeding.		
	Immediate Jeopardy	iance at a lower scope and			F580 Notification of Changes		
	· ·	ctual harm with potential for			1 560 Notification of Changes		
	· · ·	arm that is not Immediate			1. The plan of correcting the specif	ic	
		e education and ensure			deficiency. The plan should address t		
	monitoring systems p	out into place for reporting a			processes that led to the deficiency ci	ted	
	resident's change in o	condition were effective.					
					On 5/30/18, Clear Creek Nursing and		
	The findings included	l:			Rehabilitation Center was placed into		
	Desident #1 was read	dmitted to the facility on			Immediate Jeopardy at 5:00 PM for fa	-	
	09/18/14 with diagnos	dmitted to the facility on			to provide Quality of Care. The proces that led to the deficiency was determine		
	hypertension and der				to be the facility's failure to notify the	icu	
		ilenie.			family/physician/nurse practitioner of		
	Review of Resident #	1's most recent			Resident #1's change of condition wh	en	
	comprehensive Minin	num Data Set (MDS)			the resident showed signs of facial		
		2/23/18 revealed that she			drooping and drooling.		
		ired and required limited					
	assistance with her a	, .			2. The procedure for implementing	the	
		ther indicated that she had			acceptable plan of correction for the specific deficiency cited		
	others.	s usually understood by			specific deficiency cited		
					On 5/10/18, the MDS nurse's Care PI	an –	
	On 05/29/18 at 6:30 I	PM an interview was			General Note indicated Resident #1 w		
		storative Aide (RA) who			at baseline and did not indicate Resid		
		18 at approximately 1:00 PM			#1 with facial drooping or other chang	e in	
		sident #1 when she noticed			condition.		
	-	ke herself. The RA stated					
	· ·	was slurred and muffled so			On 5/11/18 earlier in the day before 1		
		urse #1 and informed the			AM, Nurse #1 did observe Resident #		
		ted observed of Resident #1			change in clarity of ZC speech, but of		
	and the Nurse Indicat	ted she was aware of			not see any facial drooping or drooling	J,	

Event ID: HCFX11

Facility ID: 070226

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TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
					С
		345562	B. WING		05/31/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	REEK NURSING & REHA			10506 CLEAR CREEK COMMERCE DRIVE	
SLEAR OF	CER NORSING & REHA	BILITATION CENTER		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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIC
F 580	Continued From page	24	F 580		
	Resident #1 towards An interview was com 05/29/18 at 3:40 PM v visitor to the facility ar Resident #1 normally on 05/11/18 at approx noticed Resident #1 v her wheelchair using arms in the air and ho made sense. The Vis mouth was drawn to o remember which side Visitor #1 stated to Nu	ducted with Visitor #1 on who stated she was a daily nd was familiar with how acted. Visitor #1 stated that kimately 2:45 PM she vas rolling herself around in her legs and flailing her ollering but nothing she said itor stated Resident #1's one side (she could not) and she was drooling. urse #1 that she thought ng a stroke and Nurse #1 ere taking care of it.		and then called the nurse practitic verify the nurse practitioner would the facility on 5/11/18. Nurse #1 is licensed practical nurse (LPN) and in the scope of practice for an LPN assess. On 5/11/18 at approximately 11:40 the physician extender nurse prace (NP) note indicated Resident #1 w by the NP. The NP note indicated "Patient seen for acute care. Mede notes reviewedalert, confused reviewed, + for leukocytes, positiv nitratespatient refuses PO medi give Rocephin 1 gram IM q24h x 3 give with lidocaine." The NP note indicate Resident #1 with right fac drooping.	be at a d it is not N to 6 AM, titioner vas seen d s, labs, UA re for ications, 3 doses, d id not
		r #2 who stated she too was		On 5/11/18 at approximately 1:00 restorative aide noticed Resident	
	behaviors of Residen arrived at the facility a	around 5:00 PM on 05/11/18 nt #1 in her wheelchair		speech was not clear while weigh and took the resident to Nurse #1	ing her
	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			On 5/11/18, at approximately 1:00 restorative aide witnessed Nurse a looking at Resident #1 and watche Nurse #1 transport Resident #1 to nurse station for observation. Nurse did not document an assessment	#1 ed o the se #1
	front lobby but on her two therapy staff in th report her concerns to after she told them of slurred speech, drooli	way to the lobby she saw e therapy gym and went to o them. Visitor #2 stated her observation of the ing and facial droop that ng, they immediately went		electronic health record. Not reco there was a change of condition, I did not notify a registered nurse (F nurse practitioner (NP), or physici to re-assess Resident #1 in the af as the day progressed on 5/11/18	ognizing LPN #1 RN), an (MD) ternoon

Facility ID: 070226

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		IO. 0938-03 E SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	· ,	G	. ,	IPLETED	
						С	
		345562	B. WING		0	5/31/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
	REEK NURSING & REHA			10506 CLEAR CREEK COMMERC	E DRIVE		
SLEAR O	REEK NORSING & REHA	BILITATION CENTER		MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE	
F 580	Continued From page	e 5	F 58	80			
		30 PM. PT #1 stated that on		reported that she attemp	ted to approach		
		ately 5:30 PM Visitor #2		Nurse #1 regarding Resi			
		y gym and reported to them		#1 stated she could not r			
		slurred speech, facial droop		visitor interaction.			
	and was drooling. Bo	oth PT #1 and PT #2 went to					
		1 and found her to have the		On 5/11/18 after 5:00 PM	•		
		Visitor #2 reported to them.		reported to Nurse #1 tha			
		nt to report their observation		was exhibiting slouched			
		ed, Resident #1 was seen by		and slurred speech. Nur			
		er (NP) earlier that day and		NP assessed the resider	-		
	was being treated for	a UTI.		and Resident #1 was on			
	On 05/20/19 at 4:24 1	DM on intensions was		for a urinary tract infection			
	On 05/29/18 at 4:34 I	IP who stated that on the		On 5/11/18 at approxima Nurse #1 administered a	-		
		she was asked by Nurse #1		injection for Resident #1.			
	-	#1 because something was		Nurse #1 did not note ob			
		NP stated she went to		drooping or drooling.	icon mig laolai		
		and she was not her normal		On 5/11/18 at the 7 PM s	shift change.		
		reviewed her urinalysis		Nurse #1 reported to me			
		nich indicated Resident #1		(MA) #1. Nurse #1 and I			
	had a UTI so she ord	lered an antibiotic for her.		report to a registered nur	rse (RN) Resident		
	The NP stated that R	esident #1 did not show any		#1's change in condition			
		f a stroke for example		drooping, drooling, and c			
		l droop or drooling or she		speech) for assessment,	failing to follow		
		to the emergency room. The		established policy.			
		e was in the facility until		On 5/12/19 at annexim	atoly 10:09 ANA		
		at no time was she alerted		On 5/12/18 at approxima registered nurse (RN) #1	-		
	to any other changes			Resident #1. The asses			
	On 05/29/18 at 5:20 I	PM an interview was		Resident #1 had a chang			
		e #1 who indicated that		(right facial drooping). R			
		taff and visitors informed her		Resident #1's physician/			
		red speech, facial droop, and		provider. The provider g	-		
		hey were the effects of the		send Resident #1 to the			
		nosed her with earlier that		department (ED) for eval			
		ed she did not call Resident		also contacted Resident			
		y (RP) nor did she notify the		representative (RR)/daug	-		
		^t 1's right side facial droop,		sent Resident #1 to the E			
	slurred speech or dro	poling.		the provider. The RR me	et Resident #1 at		

Facility ID: 070226

		ND HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/20 1 APPROVE). 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345562	B. WING			05/:) 31/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STF	REET ADDRESS, CITY, STATE, ZIP CODE	DRESS, CITY, STATE, ZIP CODE	
				105	506 CLEAR CREEK COMMERCE DRIVE		
CLEAR CI	REEK NURSING & REHA	ABILITATION CENTER		MI	NT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE
F 580	Continued From page	e 6	F.5	580			
					the ED. The resident		
	An interview was con	nducted with Nurse Aide #1			representative/daughter reported to ED	,	
	on 05/30/18 at 12:54			physician that Resident #1 was at			
		on $05/11/18$ on first and			baseline on 5/10/18. The resident		
		ated that Resident #1 was			representative/daughter also reported		
	not acting like hersel			noticing right facial drooping on the			
	and she was drooling			morning of 5/12/18.			
	-	eported her observation to			5		
		Id that Resident #1 had			On 5/12/18 through 5/16/18, the ED		
	already been evaluat	ted by the NP and was being			physician evaluation, including laborate	ory	
	treated for a UTI. NA	#1 stated that she put			and radiology test results indicated no		
	Resident #1 in the be	ed per her usual routine and			evidence that Resident #1 had a		
	when she left her shi	ft at 11:00 PM on 5/11/18			cerebrovascular (CVA), "Workup here s	so	
	Resident #1 was rest	ting in bed with her eyes			far has been normal except the fact that	t	
	closed.				she has been hypertensive, was also		
					started on antibiotics for her urinary tra-	ct	
		nducted with NA #2 on			infections yesterday." On 5/12/18,		
	05/30/18 at 11:54 AM	 she confirmed that she 			physician orders were given to discharge	ge	
		05/11/18 and stated that			Resident #1 back to the facility with no		
		n bed the entire night and			medications ordered. The discharge		
		ything different with her. The			diagnoses of CVA, DNR, dementia,		
		red incontinent care to			hyperlipidemia, and hypertension are		
	Resident #1 at appro	-			listed on the hospital discharge summa		
		the interaction she did not			Resolved diagnosis included acute cys		
		ehavior or anything out of the			without hematuria. On 5/16/18, Reside		
		#1. She stated that if she had			#1 returned to the facility with discharge	e	
		ormal with Resident #1, she			instruction for hospice evaluation.		
	would have notified the	ne nurse.			2 The monitoring procedure to creat		
	An intonviouvuses com	ductod with Nurso #2 on			3. The monitoring procedure to ensur		
		nducted with Nurse #2 on /I who confirmed he worked			that the plan of correction is effective at that specific deficiency cited remains	nu	
		8 and was responsible for			corrected and/or in compliance with the		
		-			-	-	
		rse stated that during report Resident #1 had not been			regulatory requirements		
		t had been evaluated by the			On 5/30/18, the minimum data set (MD	SI	
	-	on an antibiotic for a UTI.			RN and wound nurse RN assessed ead		
	Nurse #2 stated that				resident. The RN assessment of each		
					resident included taking vital signs, pair	n	
		and he never had to interact e added that NA #2 did not			and mental status for change in condition		
					and mental status for change in condition	011.	

Facility ID: 070226

If continuation sheet Page 7 of 37

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	1 ° <i>î</i>		· · · ·	IPLETED
					С	
		345562	B. WING		0	5/31/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
	REEK NURSING & REH			10506 CLEAR CREEK COMMERCE	DRIVE	
				MINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETIC DATE
F 580	Continued From pag	e 7	F 58	0		
		observations of Resident #1		The purpose of the asses	sments was to	
	that evening and it w			protect Resident #1 and of		
	Resident #1.	-		similar situations. The fine		
				assessments: no current	facility residents	
		nducted with Nurse #3 on		have a new/previously ur	-	
		who confirmed she worked		in condition requiring add		
		and was responsible for		assessment or physician/		
		rse stated that approximately		representative notification	1.	
		1's RP approached her and ne resident's vital signs		On 5/30/18, the director of		
		wrong with her. Nurse #3		initiated a re-education w	÷	
		not seen Resident #1 prior to		staff to include nursing as	•	
		to check her vital signs but		MAs, LPNs, and RNs. Th		
		tain Resident #1's vital signs		covered the topic of "Noti		
		y drooling or facial droop.				
	Nurse #3 stated she	asked Resident #1 to smile		"Notification of changes,		
	and she did then she	asked her to raise both		MD/NP and RP. When a		
		she did as well. Nurse #3		change in a resident, con		
		sment revealed no change		assessment and docume		
		her baseline but the RP		changes include bruises	of unknown	
	-	be sent to the Emergency		origin"		
		ation so she sent her out.		On 5/30/18, the facility as	Iministrator and	
	An interview was cor	nducted with Resident #1's		On 5/30/18, the facility ac DON consulted with the r		
		17 PM who stated that she		president (RVP) and corp	•	
		on 05/12/18 at approximately		consultant. The RVP and	-	
	-	sident #1 out for a few hours		consultant re-educated th		
	and was waiting on t	he staff to get her dressed.		and DON. The re-educat	ion covered the	
		r #1 came in and informed		topics of Quality of Care a		
		witnessed the day before		requirements for Notificat	-	
		e RP stated that when Nurse		In addition, the RVP and		
		#1 into the dining area she		consultant reviewed with		
		ime that day and noticed her		and DON topics of: 1) Ch	-	
		the right side. The RP stated #1 if she was okay and she		Condition policy, 3) failure change of condition resul		
		kay. The RP stated she then		to follow established polic	-	
		esident #1 was okay that she		importance of addressing		
		a stroke and Nurse #3 told		concerns related to Quali	-	
		vay that morning. The RP			.,	

Facility ID: 070226

If continuation sheet Page 8 of 37

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIF	IPI F	CONSTRUCTION		IO. 0938-03 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,			· /	IPLETED
				_		С	
		345562	B. WING			05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER	·	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	REEK NURSING & REHA			10	0506 CLEAR CREEK COMMERCE DRIVE		
	REEK NURSING & REHP	ABILITATION CENTER		Μ	NNT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIC DATE
F 580	Continued From page	e 8	F 58	80			
		esident #1 be sent to the ER			On 5/30/18, the corporate consultant		
		ey did. The RP explained			initiated a 100% audit of the nurse		
		fied of Resident #1's change			progress notes from 5/1/18 through		
		UTI or that she had been			5/30/18. The purpose of the audit was	s to	
	started on an antibiot	tic nor had she been			identify any needed resident assessme	ent	
		ng facial droop, slurred			for Resident #1 or other resident at ris		
		ntil the morning she was sent			a change of condition that has not bee	en	
	to the ER.				assessed and addressed through		
	A				physician/NP provider notification and	RR	
		ducted with the Director on			notification. Any resident needing	ام مر م	
		5/30/18 at 3:30 PM who prning of 05/12/18 she had			assessment will be assessed by a RN notifications made to the care provider		
		and was informed that			and RR.		
	-	s there and felt that she was					
	having a stroke. The				6/21/18 the Facility RN consultant		
		check on Resident #1 but			re-educated the IDT (Interdisciplinary		
	-	if anything was wrong with			Team) on the morning clinical meeting		
		tried to speak then she not right with Resident #1.			format, and follow up items process.		
		I she was not aware that			The facility IDT (Interdisciplinary team) will	
		naving facial droop and			review in morning clinical meeting the	, -	
	drooling after the NP				progress notes dated from previous to		
	-	The DON added if Resident			current meeting to determine potential		
	÷ .	reported to the nursing staff			changes of conditions in resident		
	-	e been reported to her as			conditions to include notification of	_	
	well.				physician and or Physician Extender a		
	On 05/20/40 -1 40:40	DM on intenviou			Resident Representative. The review		
) PM an interview was ledical Doctor (MD) who			include copies of physician orders, clir alerts that include meal intake, skin ale		
		it #1 began to display facial			incidents, care plan updates or revisio		
		slurred speech on 05/11/18,			and resident and or family concerns. T		
		assic signs of a stroke, and			DON (Director of Nursing) will docume		
		ported to the NP who was in			any follow up items that require		
		sident could be reevaluated			completion by end of day. The results	of	
	-	t to the emergency room.			the daily IDT team meeting will be		
		state that Resident #1 had			communicated to the Administrator.		
		ine neurologically and			To maintain continued the results of th		
		one well while working with			Follow up items and compliance will be		
	therapy. He added th	at when Resident #1			submitted to the Facility's QA Committ	ee	

Facility ID: 070226

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/02/2019 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345562	B. WING				C / 31/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR C	REEK NURSING & REHA	BILITATION CENTER		10	0506 CLEAR CREEK COMMERCE DRIVE		
OLLAN				М	IINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 580	presented to the ER, abnormal and indicate determine how old. T we could not identify how old it was along a age she would not hat treatment of tissue pla (treatment for stroke) Review of the Dischat hospital dated 05/16/ had presented to the scan of her head reverse indeterminate lunar (s ganglia and right that Her readmitting diager stroke. An observation was m 05/30/18 at 12:10 PW her wheelchair in the calm and no facial dow An observation was m 05/31/18 8:00 AM wh breakfast table waitin She was calm and pla facial droop was evid On 05/30/18 at 4:51 F notified of Immediate provided the following removal on 05/31/18	her scan of her brain was ed a stroke but could not he MD added that because when the stroke occurred or with Resident #1's advanced ave qualified for the asminogen activator (TPA) urge Summary from the 18 indicated Resident #1 ER on 05/12/18 and the ealed punctate age stroke) in the right basal amus (parts of the brain). hosis to the facility included a made of Resident #1 on 1 where she was sitting in common area. She was oop or drooling was noted. made of Resident #1 on there she was sitting at the ig to be served her meal. easant and no drooling or ent. PM the administration was Jeopardy. The facility g credible allegation of at 4:15 PM: ecting the specific deficiency. ress the processes that led d	F	580	monthly for three months then quarter for review and guidance. If additional issues are noted those iss will be addressed immediately and corrective action taken 4. The title of the person responsible implementing the acceptable plan of correction. The administrator will be implementing and is responsible for implementing the acceptable plan of correction.	e for	
<u> </u>	7(02-99) Previous Versions Obs	-			nility ID: 070226		t Page 10 of 27

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345562	B. WING				C 31/2018
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR C	REEK NURSING & REHA	BILITATION 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Rehabilitation Center Jeopardy at 5:00 PM of Care. The process was determined to be the family/physician/n #1's change of condit showed signs of facia 2. The procedure fa acceptable plan of co deficiency cited On 5/10/18, the MDS Note indicated Reside did not indicate Reside did not indicate Reside did not indicate Reside or other change in co On 5/11/18 earlier in t #1 did observe Reside speech, but did not se drooling, and then cal verify the nurse practif facility on 5/11/18. Nu nurse (LPN) and it is for an LPN to assess. On 5/11/18 at approxi physician extender nu indicated Resident #1 NP note indicated "Pa Meds, labs, notes rev UA reviewed, + for I nitratespatient refue Rocephin 1 Gram IM lidocaine." The NP nu #1 with right facial dro	was placed into Immediate for failing to provide Quality that led to the deficiency the facility's failure to notify purse practitioner of Resident ion when the resident if drooping and drooling. The rection for the specific anurse's Care Plan - General ent #1 was at baseline and lent #1 with facial drooping ndition. The day before 11 AM, Nurse ent #1's change in clarity of ee any facial drooping or led the nurse practitioner to itioner would be at the trise #1 is a licensed practical not in the scope of practice imately 11:46 AM, the trise practitioner (NP) note was seen by the NP. The atient seen for acute care. iewedalert, confused leukocytes, positive for ses PO medications, give q 24h x 3 doses, give with ote did not indicate Resident poping.	F	580			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345562	B. WING				C /31/2018
NAME OF P	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CLEAR C	REEK NURSING & REHA	BILITATION 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	was not clear while w resident to Nurse #1. On 5/11/18, at approx restorative aide witne Resident #1 and watc Resident #1 and watc Resident #1 to the nu Nurse #1 did not doct electronic health reco was a change of cond a registered nurse (R or physician (MD) to r afternoon as the day On 5/11/18 at approxi resident's family men attempted to approac Resident #1. Nurse # recall this specific visit On 5/11/18 after 5:00 to Nurse #1 that Resi slouched posture, dro Nurse #1 stated the N the morning and Resi therapy for a urinary t On 5/11/18 at approxi administered an antib #1. At that time, Nurse facial drooping or dro On 5/11/18 at the 7 P reported to medicatio and MA #1 did not reg (RN) Resident #1's ch	eighing her and took the simately 1:00 PM, the ssed Nurse #1 looking at ched Nurse #1 transport rse station for observation. ument an assessment in the rd. Not recognizing there dition, LPN #1 did not notify N), nurse practitioner (NP), re-assess Resident #1 in the progressed on 5/11/18. imately 2:45 PM, a different ober reported that she h Nurse #1 regarding #1 stated she could not itor interaction. PM, the therapist reported dent #1 was exhibiting boling and slurred speech. IP assessed the resident in dent #1 was on antibiotic ract infection. imately 6:00 PM, Nurse #1 biotic injection for Resident se #1 did not note observing oling. M shift change, Nurse #1 n aide (MA) #1. Nurse #1 port to a registered nurse nange in condition (right ng, and continued slurred	F	580			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION		LETED
		345562	B. WING				C 31/2018
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR CF	REEK NURSING & REHA	BILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE /INT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	On 5/12/18 at approximation program in the provider of the assessment revert change in condition (recontacted Resident # practitioner provider. to send Resident #1 the department (ED) for example, and the contacted Resident # (RR)/daughter. RN # ED as ordered by the Resident #1 at the ED representative/daught that Resident #1 was resident representative/daught that Resident #1 was resident representative noticing right facial dr 5/12/18. On 5/12/18 through 5 evaluation, including the results indicated no e had a cerebrovascula far has been normal e been hypertensive, w for her urinary tract in the the results indicated in the the representative of the term of term o	imately 10:08 AM, aled Resident #1 had a ight facial drooping). RN #1 1's physician/nurse The provider gave an order o the emergency evaluation. RN #1 also 1's resident representative 1 sent Resident #1 to the provider. The RR met 0. The resident ter reported to ED physician at baseline on 5/10/18. The re/daughter also reported ooping on the morning of /16/18, the ED physician aboratory and radiology test vidence that Resident #1 r (CVA), "Workup here so except the fact that she has as also started on antibiotics fections yesterday." On ders were given to discharge	F	580			
	medications ordered. of CVA, DNR, demen hypertension are liste summary. Resolved cystitis without hemat #1 returned to the fac instruction for hospice 3. The monitoring p plan of correction is e	The discharge diagnoses tia, hyperlipidemia, and d on the hospital discharge diagnosis included acute uria. On 5/16/18, Resident ility with discharge					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	E SURVEY PLETED
		345562	B. WING _			VE RRECTION (X5) SHOULD BE COMPLE	-
NAME OF P	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, </u>	
CLEAR C	REEK NURSING & REHA	BILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE IINT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580		e 13 egulatory requirements	F 5	580			
	wound nurse RN asse RN assessment of ea vital signs, pain, and condition. The purpo to protect Resident # similar situations. The assessments: no cur new/previously unidel requiring additional as physician/NP/residen On 5/30/18, the direct a re-education with at nursing assistants (N The re-education cov "Notification." "Notification of chang and RP. When alerted complete an assessm Reporting changes in origin"	rrent facility residents have a ntified change in condition ssessment or t representative notification. tor of nursing (DON) initiated II nursing staff to include As), MAs, LPNs, and RNs. ered the topic of es, Notification of MD/NP ed of a change in a resident, nent and document. clude bruises of unknown					
	consulted with the reg and corporate RN fac and corporate consult administrator and DO covered the topics of requirements for Noti addition, the RVP and reviewed with the adr of: 1) Change in Con assess for change of	N. The re-education Quality of Care and the fication of Changes. In d corporate consultant ministrator and DON topics idition policy, 3) failure to condition resulting from lished policy, and 4) the					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COMF	
		345562	B. WING				31/2018
NAME OF PI	ROVIDER OR SUPPLIER			ę	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR CI	REEK NURSING & REHA	BILITATION 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 580	100% audit of the nur 5/1/18 through 5/30/1 was to identify any ne for Resident #1 or oth change of condition th and addressed throug notification and RR no needing assessment		F	580			
F 684 SS=J	implementing the acc The administrator will responsible for impler of correction. Immediate Jeopardy v 5:53 PM when intervio revealed they had beer report a resident's cha who to report the char Quality of Care CFR(s): 483.25 § 483.25 Quality of car Quality of care is a fur applies to all treatment facility residents. Base assessment of a resident that residents received accordance with profe	en educated on when to ange in condition as well as nge in condition to. are ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure treatment and care in essional standards of uensive person-centered	F	684			6/29/18

Event ID: HCFX11

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/02/2 FORM APPRO OMB NO. 0938-0
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED C
		345562	B. WING		05/31/2018
NAME OF PI	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE	
CLEAR CI	REEK NURSING & REHA	BILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIV MINT HILL, NC 28227	Έ
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE COMPLET
F 684	Continued From page	e 15	F 68	4	
	-	is not met as evidenced			
	Based on observatio visitor, family, Nurse	ns, record reviews, staff, Practitioner, and Medical facility failed to assess a		F684 Quality of Care	
	cerebrovascular accie	d signs and symptoms of dent (stroke). This resulted evaluation and possible		1. The plan of correcting the s deficiency. The plan should ac processes that led to the defic	dress the
		1 of 3 residents sampled		On 5/30/18, Clear Creek Nurs	ing and
		began on 05/11/18 when b exhibit signs and symptoms		Rehabilitation Center was plac Immediate Jeopardy at 5:00 P to provide quality of care. The	M for failing
		led slurred speech, right I drooling. Nurse #1 was		that lead to the deficiency was to be the facility's failure to as	
	#1 was exhibiting slui	aff and visitors that Resident rred speech, right sided		change of condition when the practical nurse (LPN, Nurse #	1) did not
	Resident #1. Immedia	bling and did not assess ate jeopardy was removed		report to a registered nurse (R re-assessment of Resident #1	after
	and implemented an	M when the facility provided acceptable allegation of emoval. The facility remains		receiving reports of the resider signs of facial drooping and dr	
	out of compliance at a of a D (no actual harr than minimal harm th	a lower scope and severity n with potential for more at is not immediate		2. The procedure for impleme acceptable plan of correction f specific deficiency cited	
	monitoring systems p	e education and ensure ut into place for assessing a e in condition are effective.		On 5/10/18, the minimum data nurse's care plan – General N indicated Resident #1 was at t	ote
	The findings included	:		did not indicate Resident #1 was at a drooping or other change in co	ith facial
		nitted to the facility on ses that included dementia		On 5/11/18 earlier in the day b	
	and hypertension. Review of the most re	ecent comprehensive		AM, Nurse #1 did observe Res change in clarity of speech, bu	sident #1's It did not
	Minimum Data Set (M revealed that Resider	nt #1 was cognitively		see any facial drooping or droo then called the nurse practition the nurse practitioner would be	ner to verify
		d limited assistance with g. The MDS further revealed		the nurse practitioner would be facility on 5/11/18. Nurse #1 is	

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	S FUR MEDICARE &	MEDICAID SERVICES			ONB	NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	ATE SURVEY OMPLETED
						С
		345562	B. WING			05/31/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	REEK NURSING & REHA			10506 CLEAR CREEK COMMERCE DRIV	Έ	
CLEAR C	KEEK NUKSING & KEHA	BILITATION CENTER		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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	Continued From page	e 16	F 68	34		
	-	clear speech and was		it is not in the scope of practice LPN to assess.	e for an	
	noted dated 05/11/18 #1 was seen for acute laboratory values, and noted that Resident # status and was havin Resident #1 was very interacting with me w assessment revealed pleasant but confused (analysis of the urine) leukocytes (a cell that tract infection) and nii indicate a urinary tract assessment and plan (UTI): Resident #1 re	d notes were reviewed. Staff 41 has had change in mental 19 difficulty speaking. 19 confused and was not 10 hen assessed. Her 11 Resident #1 was calm and 10 d. Review of a urinalysis 1) revealed it was positive for 11 could indicate a urinary 11 trites (a cell that could 12 ct infection). The 10 read, Urinary tract infection 11 fuses to take medications by 11 in (antibiotic) 1 gram (gm)		 On 5/11/18 at approximately 1 the physician extender nurse p (NP) note indicated Resident # by the NP. The NP note indica "Patient seen for acute care. M notes reviewedalert, confuse reviewed, + for leukocytes, pos nitratespatient refuses PO m give Rocephin 1 gram IM q24H give with lidocaine." The NP m indicate Resident #1 with right drooping. On 5/11/18 at approximately 1 restorative aide noticed Reside speech was not clear while we and took the resident to Nurse 	oractitioner 41 was seen ated Meds, labs, edUA sitive for nedications, n x 3 doses, note did not facial :00 PM, the ent #1's sighing her #1.	
	05/29/18 at 4:34 PM. 05/11/18 Nurse #1 sta with Resident #1. The Resident #1 and eval laboratory values. Th that she had a UTI ar "spry" or "jovial" self. she evaluated Reside speech or any other s be having a CVA or s Resident #1 to the ho assessment and revie indicated that Reside was placed on Rocep	ducted with the NP on The NP stated that on ated "something was wrong" e NP stated she went to see luated her and reviewed her ie laboratory values indicated nd she was not her usual The NP stated at the time ent #1 she had no slurred signs that indicated she may troke or she would have sent ospital. She indicated that her ew of her medical record int #1 had a UTI and she ohin for 3 days. The NP also as not alerted to any other		On 5/11/18, at approximately 1 restorative aide witnessed Nur looking at Resident #1 and wa Nurse #1 transport Resident # nurse station for observation. I did not document her observat Resident #1 in the electronic h record. Not recognizing there change of condition, LPN #1 d a registered nurse (RN), NP, o (MD) to re-assess Resident #1 afternoon as the day progress 5/11/18. On 5/11/18 at approximately 2 different resident's family mem reported that she attempted to	se #1 tched 1 to the Nurse #1 tion of ealth was a id not notify or physician in the ed on :45 PM, a iber	

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						MB NO. 0938-03		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTIO	`	(3) DATE SURVEY COMPLETED		
			A. BUILDING			С		
		345562	B. WING			05/31/2018		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE	00/01/2010		
				10506 CLEAR CREEK COMMERCE DRIVE				
SLEAR CI	REEK NURSING & REHA	BILITATION CENTER		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	(EAG	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE		
F 684	Continued From page	e 17	F 68	1				
	day.		1 00		she could not recall this specifi	c		
				visitor inte	-	~		
	An interview was con	ducted 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			8 after 5:00 PM, the therapist			
				o Nurse #1 that Resident #1				
	the facility. While weight			iting slouched posture, drooling	-			
	approximately 1:00 P	acting like herself, she was			d speech. Nurse #1 stated the sed the resident in the morning			
		vas slurred and muffled. The			ent #1 was on antibiotic therap			
		pushed Resident #1 in her			ry tract infection.			
		, ≠1 and informed her that her			8 at approximately 6:00 PM,			
	speech was slurred a	nd she was not acting like		Nurse #1 a	administered an antibiotic			
	herself. She stated N	urse #1 indicated that she		injection fo	or Resident #1. At that time,			
		nt #1's condition and pushed			did not note observing facial			
	Resident #1 back tow	vards her room.		drooping c	or drooling.			
	An interview was con	ducted with Visitor #1 on		On 5/11/18	8 at the 7 PM shift change,			
		Visitor #1 indicated she		Nurse #1 r	reported to medication aide			
		on 05/11/18 at approximately			Nurse #1 and MA #1 did not			
		Resident #1 rolling around			RN Resident #1's change in			
	-	nothing she said made any			(right facial drooping, drooling,			
		dicated that Resident #1 was			nued slurred speech) for			
	flailing her arms arou	th was drawn to one side		policy.	nt, failing to follow established			
		all which side. Visitor #1		poney.				
		#1 and stated to her "I		On 5/12/18	8 at approximately 10:08 AM,			
	think Resident #1 is h	aving a stroke." Visitor #1			sessed Resident #1. The			
		replied "we are taking care		assessme	nt revealed Resident #1 had a			
		Visitor #1 stated that later in			condition (right facial drooping).		
	· ·	or #2 that something was			ntacted Resident #1's			
		#1. Visitor #1 stated she did			nurse practitioner provider. Th			
		and check on Resident #1			ave an order to send Resident			
	during her time in the	radinty.			emergency department (ED) for . RN #1 also contacted			
	An interview was con	ducted with Visitor #2 on			#1's resident representative			
		Visitor #2 stated that she			hter. RN #1 sent Resident #1			
		on 05/11/18 at approximately			as ordered by the provider. Th	ne		
	-	ormed by Visitor #1 that			esident #1 at the ED. The			
		g with Resident #1. Visitor #2		resident re	epresentative/daughter reported	ч		

Facility ID: 070226

If continuation sheet Page 18 of 37

			()(0)			0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING	J	с	
		345562	B. WING			1/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		1/2010
				10506 CLEAR CREEK COMMERC		
CLEAR CI	REEK NURSING & REHA	BILITATION CENTER		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 (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	. 19	E CO			
F 004	p p p p		F 68	-	Decident #1 was	
		ved Resident #1 in her naking all kinds of noises		to the ED physician that at baseline on 5/10/18.		
		lurred and she couldn't talk.		representative/daughter		
		went to look for someone to		noticing right facial droop		
	help Resident #1 and	found Physical Therapist		morning of	-	
	(PT) #1 and #2 and a	sked them to check on		5/12/18.		
	Resident #1.					
				On 5/12/18 through 5/16		
		ducted with PT #1 and PT		physician evaluation, inc		
		0 PM. PT #1 stated that on		and radiology test result		
	came to the therapy g	ately 5:30 PM Visitor #2		evidence that Resident cerebrovascular (CVA),		
		red speech, she had facial		far has been normal exc	-	
		ng. PT #1 indicated that she		she has been hypertens	-	
	grabbed PT #2 and th	-		started on antibiotics for		
	-	nd her to exhibit the same		infections yesterday." O	-	
	symptoms described"	by Visitor #2. PT #1 stated		physician orders were gi	iven to discharge	
	that they went to Nurs			Resident #1 back to the	-	
		on. PT #1 stated that Nurse		medications ordered. The	-	
		is aware of Resident #1's		diagnoses of CVA, do no		
		d been seen by the NP		(DNR), dementia, hyper	-	
		as being treated for a UTI. in informed Nurse #1 of her		hypertension are listed of discharge summary. Re		
		it #1's facial droop and again		included acute cystitis w	<u> </u>	
		was aware. Both PT #1 and		On 5/16/18, Resident #1		
		rse #1 assess Resident #1		facility with discharge ins		
	and after they informe			hospice evaluation.		
	-	ed to the therapy gym to				
	complete their work.			3. The monitoring proce		
				that the plan of correctio		
		ducted with Nurse #1 on		that specific deficiency of		
		Nurse #1 indicated that on		corrected and/or in comp		
		e was informed that the NP Resident #1 because she		regulatory requirements		
		erself. Nurse #1 stated that				
		eract with Resident #1 that		On 5/30/18, the MDS RM	N and wound	
		e was passing medication		nurse RN assessed eac		
	and Resident #1 was			RN assessment of each		
		1 stated around lunch time		taking vital signs, pain, a		

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						0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMF	PLETED
			A. BUILDING	G		С
		345562	B. WING			
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI		31/2010
				10506 CLEAR CREEK COMMERC		
CLEAR C	REEK NURSING & REHA	BILITATION CENTER		MINT HILL, NC 28227		
		ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN		(XE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	e 19	F 68	84		
	the RA brought Resid	lent #1 to me stated that she		for change in condition.	The purpose of	
		erself and her speech was		the assessment was to p		
		icated she was aware of her		#1 and other residents in		
	-	nat the NP had seen her and		situations. The findings of		
		otic for a UTI. Nurse #1		assessments: no curren		
		the day two PTs had come		have a new/previously u		
		lent #1 was not acting like		in condition requiring add		
		biting slurred speech, facial		assessment or physician	/NP notification.	
		Nurse #1 stated that she				
	-	#2 that she had already		On 5/30/18, the director	÷ · ·	
		she was being taken care of. she did not think she needed		initiated a re-education w	•	
		sident #1 because the NP		MAs, LPNs, and RNs. T		
	-	d her earlier in the day.		covered the topic of "Not "Notification of changes,	ification."	
	A follow up interview	was conducted with Nurse		MD/NP and RP. When a		
		:26 AM. Nurse #1 confirmed		change in a resident, cor		
		ot assessed Resident #1 for		assessment and docume	-	
	U U	and did not ask any other		changes include bruises		
	-	dent #1. She acknowledged		origin"		
	that the RA, Visitor #	-				
		ns to her about Resident		On 5/30/18, the facility a	dministrator and	
		facial droop, and drooling		DON consulted with the		
	but she believed that	they were all effects from		president (RVP) and corp		
	her UTI. Nurse #1 sta			consultant. The RVP and	•	
		to her earlier that day she		consultant re-educated th		
		#1 again until 6:00 PM when		and DON. The re-educa		
		er her ordered antibiotic		topics of Quality of Care		
		ime she did not notice any		requirements for Notifica	•	
	change to her conditi	UII.		In addition, the RVP and consultant reviewed with	-	
	An interview was con	ducted with Nursing		and DON topics of: 1) C		
		05/30/18 at 12:54 PM. NA		Condition policy, 3) failur		
		e took care of Resident #1		change of condition resu		
		nd 2nd shift. She stated that		to follow established poli	-	
		acting like herself and her		importance of addressing		
		and she was drooling from		concerns related to quali		
		h. NA #1 stated that she			-	
	alerted Nurse #1 and	was told that Resident #1		On 5/30/18, the corporat	e facility	

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		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
					С
		345562	B. WING		05/31/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE
CLEAR C	REEK NURSING & REHA	BILITATION CENTER		10506 CLEAR CREEK COMMERCE MINT HILL, NC 28227	DRIVE
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 684	Continued From page	e 20	F 68	84	
	routine and when she 05/11/18, Resident # eyes closed. An interview was con 05/30/18 at 11:54 AM worked 3rd shift on 0 Resident #1 rested in she did not notice an #2 stated that she ren Resident #1 at appro 05/12/18 but during th notice any usual behav normal with Resident	the bed per her usual e left her shift at 11:00 PM on 1 was resting in bed with her ducted with NA #2 on 1. NA #2 confirmed that she 5/11/18 and stated that bed the entire night and ything different with her. NA indered incontinent care to ximately 5:00 AM on hat interaction she did not avior or anything out of the #1. She added that if she ny abnormal behavior she		 5/30/18. The purpose of the identify any needed resider for Resident #1 or other rest a change of condition that assessed and addressed in physician/NP provider not in notification. Any resident assessment will be assess notifications made to the chand RR. On 6/22/18, the corporate consultant re-educated the Interdisciplinary Team (IDT but not limited to the DON Development Coordinator) 	ent assessment esident at risk of has not been through fication and RR needing sed by a RN and eare provider facility e T)- that includes , Staff
	05/31/18 at 12:50 PM he was working 3rd s responsible for Resid during report he was had not been acting I evaluated by the NP UTI. Nurse #2 stated throughout the night a with Resident #1 that	ducted with Nurse #2 on 1. Nurse #2 confirmed that hift on 05/11/18 and was ent #1. Nurse #2 stated that notified that Resident #1 ike herself but had been and was on antibiotic for that Resident #1 rested and he never had to interact night. He added that NA #2 usual behavior that evening		 treatment nurse, MDS Nur manager, activity director representative and social a morning clinical meeting fo follow up items process. N members will receive train morning clinical meeting d by the SDC. The nurse that is assigned is responsible for the asse resident when a change of been identified. If the char during a time when a RN i 	, rehab services - on the ormat, and lewly hired IDT ing on the uring orientation I to the resident ssment of the f condition has age occurs s not on duty –
	05/31/18 at 1:01 PM. she worked 05/12/18 responsible for Resid approximately 10:00	ducted with Nurse #3 on Nurse #3 confirmed that on 1st shift and was ent #1. Nurse #3 stated that AM Resident #1's family asked that Resident #1's		the licensed nurse or the N RN on call and relay the p The on-call RN will then be for completing the assess resident. On 6/25/18, the DON bega	ertinent data. e responsible ment of the

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						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
						С
		345562	B. WING		0	5/31/2018
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE	, ZIP CODE	
				10506 CLEAR CREEK COMME	RCE DRIVE	
	REEK NURSING & REHA	ABILITATION CENTER		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	(EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE
F 684	Continued From page	e 21	F 68	34		
		d because there was	1.00	the MAs, LPNs, and R	Ns on the process	
		h her. Nurse #3 stated that		for assessment and ch	•	
		sident #1 prior to the family		and notification to the	-	
		ck Resident #1's vital sings.		extender and resident		
	Nurse #3 stated that	when she went to obtain		Newly hired nurses an	nd medications aides	
		gns she did not notice any		will receive the educat		
	-	op. She stated that she		assessment and chan	-	
		smile and she did and she		notification during thei	r orientation period.	
		lift both her arms in the air				
		do that. Nurse #3 stated that aled no change in Resident		The facility IDT will rev clinical meeting the pr		
		but the family requested that		from previous to curre		
		to the Emergency Room		determine potential ch	-	
		nd so she sent her out.		in resident conditions	•	
				notification of physicia	n and or Physician	
	An interview was cor	ducted with Resident #1's		Extender and Resider	t Representative.	
	family on 05/29/18 at	-		The review will include		
		she had visited Resident #1		orders, clinical alerts t		
		nd her to be in her usual		intake, skin alerts, inci		
		amily member stated that		updates or revisions, a		
	she came to the facil	AM and was sitting in the		family concerns. The I		
		on the staff to get her family		any follow up items the completion by end of c		
		e added that Visitor #1 came		the daily IDT team me	•	
		amily member of what she		communicated to the a	-	
		/11/18 with Resident #1. The				
	family member stated			To maintain continued	the results of the	
		ember into the dining room		follow-up items and co	-	
		r for the first time that day		submitted to the facilit		
		her mouth was drawn to the		assurance/performance		
	•	ated she asked Resident #1		Committee monthly fo		
		Resident #1 stated "no I am		quarterly for review an	•	
	-	*1's family member stated to ly member ok she looks like		additional issues are r will be addressed imm		
	-	" and Nurse #3 replied "she		corrective action taker	-	
		norning." Resident #1 stated				
		#3 she wanted her family				
		he ER for evaluation and		4. The title of the pers	son responsible for	
	they did.			implementing the acce		

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		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/02/2019 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	СОМ	E SURVEY PLETED
		345562	B. WING _				C / 31/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				10	0506 CLEAR CREEK COMMERCE DRIVE		
CLEAR CI	REEK NURSING & REHA	BILITATION CENTER		Μ	IINT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page	e 22	F 684				
					correction.		
		ducted with NA #3 on					
	was working on 05/12 stated that Resident and look at Resident	NA #3 confirmed that she 2/18 on 1st shift. NA #3 #1's family asked her to go #1. NA #3 stated that the she noticed her face was			The administrator will be implementing and is responsible for implementing the acceptable plan of correction.	-	
	drawn to the right sid someone who had a she summoned the D	e and she looked like stroke. NA #3 stated that Director of Nursing (DON) to sident #1 and she had her					
	05/30/18 at 3:30 PM. morning of 05/12/18 s NA #3 informed her th member was in the fa #1 was having a strol immediately proceed. Resident #1 and initia not tell anything was started to speak she right. The DON stated was very slurred and were on the way. She that they were on the Resident #1 was tran evaluation. The DON that on 05/11/18 som evaluated by the NP droop and drooling an	ducted with the DON on The DON stated that on the she arrived at the facility and hat Resident #1's family acility and thought Resident ke. The DON stated she ed to go and check on ally by looking at her could wrong but when Resident #1 knew something was not d that Resident #1's speech she asked if the medics e added that Nurse #3 stated way to the facility and usported to the ER for stated she was not aware etime after Resident #1 was she began to have facial nd if these symptoms were ng staff they should have					
	Doctor (MD) on 05/30 stated that if Residen	ducted with the Medical D/18 at 12:10 PM. The MD It #1 began to display facial slurred speech those were					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345562	B. WING				C / 31/2018
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	
CLEAR C	REEK NURSING & REHA	BILITATION 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 684	these symptoms were staff on 05/11/18 the should have been reev immediately out to the Resident #1 had return neurologically and ph while working with the Resident #1 presente brain was abnormal a could not determine the because we could no occurred or how old if #1's advanced age sh for the treatment of tis (TPA) (treatment for sh Review of the dischar hospital dated 05/16/7 #1 had presented to the scan of her head rever indeterminate lacunar basal ganglia and righ brain). Her readmittin included CVA (stroke) An observation was m 05/30/18 at 12:10 PM her wheelchair in the calm and no facial dro An observation was m 05/31/18 at 8:00 AM. the breakfast table was	stroke. The MD stated that if e reported to the nursing NP who was in the building ide aware so Resident #1 raluated and sent e ER. The MD stated that rned to her baseline ysically and had done well erapy. He added that when d to the ER her scan of her ind indicated a stroke but how old. The MD added that t identify when the stroke t was along with Resident he would not have qualified ssue plasminogen activator stroke). The Sindicated that Resident he ER on 05/12/18 and ealed punctate age r infarcts (stroke) in the right at thalamus (parts of the g diagnoses to the facility). The de of Resident #1 on the Resident #1 was sitting in common area. She was pop or drooling was noted. The added facility at aiting to be served her meal. easant and no facial droop	F	684			

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRU			(X3) DATE COMF	
		345562	B. WING					31/2018
NAME OF P	ROVIDER OR SUPPLIER	I		STREETADD	DRESS, CITY, STATE, ZIP COD)E		
CLEAR C	REEK NURSING & REHA	BILITATION CENTER	10506 CLEAR CREEK COMMERCE MINT HILL, NC 28227			E DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APP DEFICIENCY) DEFICIENCY)						(X5) COMPLETION DATE
F 684	F 684 Continued From page 24 5/31/18, 4:15 PM F684 1. The plan of correcting the specific deficiency.		F 6	84				
		ess the processes that led						
	Jeopardy at 5:00 PM of Care. The process was determined to be assess for change of practical nurse (LPN, a registered nurse (R Resident #1 after rec showing signs of facia The nurse recognized condition and believe addressed the reside an assessment and p the diagnosis of urina 2. The procedure f	was placed into Immediate for failing to provide Quality that lead to the deficiency e the facility 's failure to condition when the licensed Nurse #1) did not report to N) for re-assessment of eiving reports of the resident al drooping and drooling. d the resident 's change in d the nurse practitioner nt 's needs by performing prescribing an antibiotic for						
	Note indicated Residu did not indicate Residu or other change in co On 5/11/18, earlier in Nurse #1 did observe clarity of speech and drooping or drooling e the nurse practitioner practical nurse (LPN)	nurse's Care Plan - General ent #1 was at baseline and lent #1 with facial drooping ndition. the day before 11 AM, e Resident #1's change in did not see any facial earlier in the day and did call . Nurse #1 is a licensed and it is not in the scope of o assess. Not recognizing						

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TATEMENT C	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTI	IPLE C	ONSTRUCTION	(X3) DATE	
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG			PLETED
		345562	B. WING				C
	ROVIDER OR SUPPLIER	545562			EET ADDRESS, CITY, STATE, ZIP CODE	05/	31/2018
	CONDER OR SOFFLIER				06 CLEAR CREEK COMMERCE DRIVE		
CLEAR CF	REEK NURSING & REHA	BILITATION CENTER			NT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 684	Continued From page	25		<u>`04</u>			
1 004			F 6	084			
	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 approx	imately 11:46 AM, the					
	Physician Extender n	urse practitioner (NP) note					
	indicated Resident #1	I was seen by the NP. The					
		atient seen for acute care.					
		viewedalert, confused					
		leukocytes, positive for					
	-	ses PO medications, give					
		q24h x 3 doses, give with ote did not indicate Resident					
	#1 with right facial dro						
	On 5/11/18 at approx						
		ed Resident #1's speech					
		eighing her and took the					
	resident to Nurse #1.						
	witnessed Nurse #1 I	ooking at Resident #1 and					
	watched Nurse #1 tra	ansport Resident #1 to the					
		ervation. Nurse #1 did not					
		ment in the electronic health					
	record.						
		imately 2:45 PM, a different					
		nber reported that she h Nurse #1 regarding					
		#1 stated she could not					
	recall this specific vis						
	•	PM, the therapist reported					
		dent #1 was exhibiting					
		poling and slurred speech.					
		NP assessed the resident in					
	-	ident #1 was on antibiotic					
	therapy for a urinary						
		imately 6:00 PM, Nurse #1					
		piotic injection for Resident					
		se #1 did not note observing					
	facial drooping or dro						

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						IO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	TE SURVEY MPLETED
			A. BUILDING			С
		345562	B. WING			
		545502		STREET ADDRESS, CITY, STATE, ZIP COD		5/31/2018
NAME OF PI	ROVIDER OR SUPPLIER			10506 CLEAR CREEK COMMERCE DRIVE		
CLEAR CI	REEK NURSING & REH	ABILITATION CENTER			VE	
				MINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	Continued From pag	e 26	F 68	4		
	-	PM shift change, Nurse #1				
		on aide (MA) #1. Nurse #1				
		port to a registered nurse				
		change in condition (right				
		ling, and continued slurred				
	speech) for assessm	ent, failing to follow				
	established policy.					
	On 5/12/18 at approx	· · · · · · · · · · · · · · · · · · ·				
		I) #1 assessed Resident #1.				
		ealed Resident #1 had a				
		(right facial drooping). RN #1				
	contacted Resident #					
	to send Resident #1	The provider gave an order				
		evaluation. RN #1 also				
		#1's resident representative				
		#1 sent Resident #1 to the				
		e provider. The RR met				
	Resident #1 at the E					
		nter reported to the ED				
		ent #1 was at baseline on				
	5/10/18. The resider	nt representative/daughter				
	also reported noticing morning of 5/12/18.	g right facial drooping on the				
		5/16/18, the ED physician				
		laboratory and radiology test				
		evidence that Resident #1				
		ar (CVA), "Workup here so				
		except the fact that she has				
		vas also started on antibiotics				
		nfections yesterday." On				
		ders were given to discharge				
	Resident #1 back to	. The discharge diagnoses				
		ntia, hyperlipidemia, and				
		ed on the hospital discharge				
		diagnosis included acute				
	-	-				
	CVSIIIIS WIINOUT NEMA	ituria. On 5/16/18, Resident				

Facility ID: 070226

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMF	LETED
							C
		345562	B. WING			05/	31/2018
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	REEK NURSING & REHA	BILITATION CENTER		1	10506 CLEAR CREEK COMMERCE DRIVE		
				Ν	MINT HILL, NC 28227		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFI	v	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	F	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
F 684	Continued From page	e 27	F	684			
	instruction for hospice	e evaluation.					
		procedure to ensure that the					
		ffective and that specific					
	•	ins corrected and/or in					
		egulatory requirements					
	On 5/30/18, the minir	num data set (MDS) RN and					
		essed each resident. The					
	RN assessment of ea	ach resident included taking					
		mental status for change in					
		se of the assessments was					
	•	1 and other residents in					
	similar situations. The	rent facility residents have a					
		ntified change in condition					
		ssessment or physician/NP					
	notification.						
	On 5/30/18, the direc	tor of nursing (DON) initiated					
	a re-education with a	Il nursing staff to include					
		As), MAs, LPNs, and RNs.					
	The re-education cov	ered the topic of					
	"Notification."	Notification of MD/ND					
	-	es, Notification of MD/NP ed of a change in a resident,					
	complete an assessm						
		iclude bruises of unknown					
	origin"						
	On 5/30/18, the facilit	ty administrator and DON					
		gional vice president (RVP)					
		cility consultant. The RVP					
l	and corporate consul						
	administrator and DC						
		Quality of Care and the fication of Changes. In					
		d corporate consultant					
		ministrator and DON topics					
		idition policy, 3) failure to					

Facility ID: 070226

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER.	A. BUILDI	NG _			C
		345562	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR C	REEK NURSING & REHA	BILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE /INT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	 failure to follow estable importance of address concerns related to Q On 5/30/18, the corport 100% audit of the num 5/1/18 through 5/30/1 was to identify any needing assessment and addressed throug notification and RR needing assessment and notifications mad RR. 4. The title of the perimplementing the accord The administrator will responsible for implementing the accord to correction. 	condition resulting from lished policy, and 4) the sing resident/family uality of Care. orate consultant initiate a se progress notes from 8. The purpose of the audit eeded resident assessment eer resident at risk of a nat has not been assessed gh physician/NP provider otification. Any resident will be assessed by a RN e to the care provider and erson responsible for eptable plan of correction. be implementing and is menting the acceptable plan	F	584			
F 770 SS=D	conducting assessme condition was reporte included if the nurse v	ents when a change of d. The education also was unable to assess the ectation was that they report assess the resident.	F	770			6/29/18
	laboratory services to	cility must provide or obtain					

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STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		345562	B. WING				C / 31/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER	1	10	IREET ADDRESS, CITY, STATE, ZIP CODE 0506 CLEAR CREEK COMMERCE DRIVE INT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 770	requirements for labor of this chapter. This REQUIREMENT by: Based on record rev facility failed to obtain which was ordered by	services. les its own laboratory s must meet the applicable pratories specified in part 493 is not met as evidenced iews and staff interviews the n a resident's urine sample y the physician for a culture f 3 residents reviewed for	F	770	F 770 Laboratory Services The plan of correcting the specific deficiency. The plan should address processes that led to the deficiency of	ited	
		l: dmitted to the facility on ses which included dementia			The position of Clear Creek Nursing a Rehabilitation Center regarding the process that led to the deficiency was determined to be the facility's failure to notify the physician/nurse practitioner difficulty obtaining Resident #1's lab specimen to carry out the physician's order for urine culture and sensitivity.	s to r of	
	required limited assis activities of daily livin	•			The facility obtained the specimen or 05/09/18 and the results were communicated to the Nurse Practition and appropriately addressed. The procedure for implementing the acceptable plan of correction for the specific deficiency cited	her	
	05/29/18 revealed in incontinence related to risk for a urinary tract will be free from a UT interventions of enco- intake, providing peri	1's Care Plan revised on part a focus of urinary to cognitive impairment, at infection (UTI). Resident #1 I by utilizing the uraging adequate fluid care after each incontinent ng for and reporting signs			An 100% audit was started 5/31/18 b Director of Nursing (DON) of all labor order for the past 30 days to ensure laboratory samples were drawn, rece and communicated to physician in a t manner. The audit was completed an revealed no further negative findings. The monitoring procedure to ensure to	atory ived, timely id	

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							. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCT		(X3) DATE COMPI	
			A. BUILDING				
		345562	B. WING				, 31/2018
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRE	ESS, CITY, STATE, ZIP CODE	, 000	
				10506 CLEAR	CREEK COMMERCE DRIVE		
CLEAR C	REEK NURSING & REHA	ABILITATION CENTER		MINT HILL, N	IC 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 CORRECTION ACH CORRECTIVE ACTION SHOULD I DSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 770	Continued From page	e 30	F 77				
4 	and symptoms of UT	ls.		specific o	of correction is effective and t deficiency cited remains corre compliance with the regulated	ected	
		#1's Physician's order dated by Nurse # 4 revealed an		requirem	ients		
	order to obtain a urin sensitivity (C&S whic germ and the antibiot inhibit the growth of t		initiated a staff to in	18, the director of nursing (De a re-education with all nursing nclude nursing assistants (NA Ns, and RNs. The re-educati	g .s),		
	Poviow of Posidont t	t1's Prograss pata written by			the topic of "Notification."	f	
		*1's Progress note written by 05/09/18 at 14:58 PM stated r lab to pick up".		MD/NP a change i assessm	tion of changes, Notification o and RP. When alerted of a n a resident, complete an nent and document. Reporting include bruises of unknown		
		#1's Progress notes dated h 05/09/18 revealed no other		origin"			
		ining to the urine sample was		DON cor presiden	18, the facility administrator a nsulted with the regional vice t (RVP) and corporate RN fac nt. The RVP and corporate		
	conducted with Nurse received the order for	' PM an interview was e #4 who stated when she r Resident #1's urine culture ed two times before the end		consultar and DON topics of	nt re-educated the administra N. The re-education covered Quality of Care and the nents for Notification of Chang	the	
	of her shift (7:00 PM) unsuccessful becaus cooperate. The Nurse	to obtain the urine but was e Resident #1 would not e stated she reported it to at she was unsuccessful.		to include physiciar	e notification of physician and n extender if lab specimens a to be obtained as ordered.	lor	
	Also during the interv 05/09/18 she realized	view, Nurse #4 stated that on d Resident #1's urine had not nurse aide brought it to her		re-educa Team) or	the Facility RN consultant ated the IDT (Interdisciplinary n the morning clinical meeting and follow up items process.	1	
	Nurse #2 he stated th) PM during an interview with ney tried several times to e from Resident #1 during		review in progress	ity IDT (Interdisciplinary team morning clinical meeting the notes dated from previous to neeting to determine potentia)	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
IND FLAN OF	CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING		C
		345562	B. WING		05/31/2018
NAME OF PI	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
CLEAR CI	REEK NURSING & REHA	ABILITATION 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTIO
F 770	Continued From page	e 31	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. 			changes of conditions in resident conditions to include notification of physician and or Physician Extender Resident Representative. The review include copies of physician orders including lab orders to include obtain specimens and results, clinical alerts include meal intake, skin alerts, incide care plan updates or revisions, and resident and or family concerns. The (Director of Nursing) will document an follow up items that require completic end of day. The results of the daily II team meeting follow up will be communicated to the Administrator.	v will ing that ents, DON ny on by
		Its of Resident #1's urine had a urinary tract infection biotic for treatment.		To maintain continued the results of t Follow up items and compliance will I shared by the Administrator with the Facility's QA Committee monthly for t months then guarterly for review and	be
	conducted on 05/31/ the fact that Resident obtained after a few of	ector of Nurses (DON) was 18 at 5:45 PM. She revealed t #1's urine could not be days, did not concern her as the NP was not notified that obtain it.		guidance. If additional issues are noted those is will be addressed immediately and corrective action taken	ssues
	12:10 PM he stated h Resident #1's urine for	vith the MD on 05/30/18 at he wrote the order to obtain or a C&S and if the urine d within a day then he should		 2. The title of the person responsib 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 - lo CFR(s): 483.20(f)(5),	dentifiable Information	F 842	2	6/29/18

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	-					FORM	APPROVED
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
		345562	B. WING			28227 DVIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE	
NAME OF P	PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 345562 B. WING WE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE EAR CREEK NURSING & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE X4) ID REFIX 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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)						
CLEAR CI	REEK NURSING & REHA	BILITATION CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 842	 (i) A facility may not reresident-identifiable to resident-identifiable to accordance with a coagrees not to use or cexcept to the extent the to do so. §483.70(i) Medical registrations and and must maintain medicat that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The facial information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitti with 45 CFR 164.506 (iv) For public health and an enforcement purp purposes, research purp medical examiners, fur a serious threat to head to accomplete to the end to activities of the end to activate to head the end to a complete to a serious threat to head the end to activate to the end tot activate to	elease information that is o the public. lease information that is o an agent only in intract under which the agent disclose the information he facility itself is permitted cords. dance with accepted is and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential hed in the resident's records, n or storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance ; activities, reporting of abuse, violence, health oversight administrative proceedings, poses, organ donation	F	842			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/02/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345562	B. WING		C 05/31/2018
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
CLEAR C	REEK NURSING & REHA	ABILITATION CENTER		0506 CLEAR CREEK COMMERCE DRIVE /INT 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 SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 842	Continued From page	e 33	F 842		
	§483.70(i)(3) The fac	ility must safeguard medical gainst loss, destruction, or			
	for- (i) The period of time (ii) Five years from th there is no requirement	ars after a resident reaches			
	 (i) Sufficient informat (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review e 				
	professional's progre (vi) Laboratory, radio services reports as re	e's, and other licensed			
	Based on medical re interviews, the facility unsuccessful attempt	ts over 6-day period to obtain dered by the physician for 1 ent #1) reviewed for		F 842 Resident Records The plan of correcting the specific deficiency. The plan should addres processes that led to the deficiency	
	Findings included:			The position of Clear Creek Nursing Rehabilitation Center regarding the process that led to the deficiency w determined to be the facility's failur document the difficulty obtaining Re	as e to
		nitted to the facility on ses that included dementia		#1's lab specimen to carry out the physician's order for urine culture a	nd

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		ID HUMAN SERVICES MEDICAID SERVICES	-			FORM	D: 01/02/20 MAPPROVE D. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345562	B. WING				31/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CLEAR CI	REEK NURSING & REHA	BILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE		
				M	INT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 842	Continued From page	e 34	E F	842			
	and hypertension.			0.2	sensitivity.		
	had clear speech and	IDS) dated 02/23/18 was cognitively impaired, was usually understood by ther indicated Resident #1 assistance with most g and was frequently			The facility obtained the specimen on 05/09/18 and the results were communicated to the Nurse Practitione 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 Director of Nursing (DON) of all labora orders and progress notes for the past	the tory	
	revealed an order dat urine sample for cultu performed to identify	an orders for Resident #1 ted 05/04/18 to obtain a ure and sensitivity (test the germs that cause the nd of medication will work tion).			days to ensure laboratory samples we drawn, received, and communicated to physician in a timely manner. The aud was completed and revealed no furthe negative findings.	re D it	
	05/04/18 through 05/ dated 05/09/18 which lab to pick up." Furth	progress notes for the period 09/18 revealed an entry n read, "urine put in fridge for er review revealed no other empts to obtain a urine			The monitoring procedure to ensure the the plan of correction is effective and to specific deficiency cited remains corre- and/or in compliance with the regulato requirements On 5/30/18, the director of nursing (DC initiated a re-education with all nursing staff to include nursing assistants (NA: MAs, LPNs, and RNs. The re-education	hat cted ry DN) I s),	
	#1 dated 05/10/18 ret tract infection and red treatment.	ulture results for Resident vealed she had a urinary quired an antibiotic for			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 a DON consulted with the regional vice	o of nd	
	Nurse #4 revealed sh 05/04/18 to obtain a u	n 05/31/18 at 12:17 PM he received an order on urine sample for Resident #1 before the end of her shift			president (RVP) and corporate RN fac consultant. The RVP and corporate consultant re-educated the administrat and DON. The re-education covered t	tor	

Event ID: HCFX11

Facility ID: 070226

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		· · ·	MPLETED
						С
		345562	B. WING			5/31/2018
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD	E	
	REEK NURSING & REHA			10506 CLEAR CREEK COMMERCE DRI	VE	
				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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE
F 842	Continued From page	e 35	F 84	2		
		insuccessful because		topics of Quality of Care and	the	
		ot cooperate. Nurse #4		requirements for Notification		
	confirmed she report	•		to include notification/ docum	-	
	attempts to obtain the	e urine sample to Nurse #2		physician and or physician ex	tender if lab	
	÷ .	t did not document it in		specimens are not able to be	obtained as	
	Resident #1's medica	al record.		ordered.		
				6/22/18 the Facility RN consu		
	During on interview of	on 05/31/18 at 12:50 PM		re-educated the IDT (Interdise Team) on the morning clinical		
	•	aff tried several times to		format, and follow up items p		
		e from Resident #1 during			000033.	
		7:00 AM on 05/04/18 but was		The facility IDT (Interdisciplin	ary team) will	
	unsuccessful. Nurse	#2 confirmed he did not		review in morning clinical me	•	
	document the attemp	ots to obtain a urine sample		progress notes dated from pro	evious to	
	in Resident #1's med	ical record.		current meeting to determine	-	
				changes of conditions in resid		
	During and interview.			conditions to include notification		
		on 05/31/18 at 1:24 PM vas unable to recall the exact		physician and or Physician E: Resident Representative. The		
		d by the Nurse to obtain a		include copies of physician or		
	•	esident #1 but did recall		including lab orders to include		
		ccessful attempts over the		specimens and results, clinica	•	
	÷	NA #2 added she was finally		include meal intake, skin aler		
	successful in obtainin	ng the urine sample from		care plan updates or revision	s, and	
	Resident #1 on 05/09	9/18.		resident and or family concer		
				(Director of Nursing) will docu		
	During an interview	DE 121/10 at 5:45 DEA 45 -		follow up items that require co	•	
		on 05/31/18 at 5:45 PM the DON) indicated staff should		end of day. The results of the team meeting follow - up will		
		dical provider within 24 hours		communicated to the Adminis		
		when they were unable to				
		e for Resident #1. The DON		To maintain continued the ad	ministrator	
	added she would have	ve expected for staff to		will share the results of the Fe		
	-	Resident #1's medical record		items and compliance will be		
		vhy the urine sample was		the Facility's QA Committee r	-	
	unable to be obtained	d.		three months then quarterly for	or review and	
				guidance.	thoop incurs	
				If additional issues are noted will be addressed immediate		

Event ID: HCFX11

Facility ID: 070226

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/2019 1 APPROVED). 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	345562		B. WING				_ 31/2018
NAME OF PF	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
CLEAR CF	REEK NURSING & REHA	BILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE		
		-		N	IINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 842	Continued From page	2 36	F	842			
				0.2	corrective action taken		
					 The title of the person responsible implementing the acceptable plan of correction. The Director of Nursing will be implementing and is responsible for the acceptable plan of correction. 		
	7(02-99) Previous Versions Obs	olete Event ID: HC			rility ID: 070226		t Page 37 of 37

Facility ID: 070226

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DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED	
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED R-C	
		345562	B. WING	B WING				
NAME OF P	ROVIDER OR SUPPLIER	040002		S	TREET ADDRESS, CITY, STATE, ZIP CODE	05	/31/2018	
					0506 CLEAR CREEK COMMERCE DRIVE			
CLEAR C	REEK NURSING & REHA	BILITATION CENTER		N	IINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS	;	{F 0	000}				
	483.25 (F684) at J 5 5/31/2018.	See event ID HCFX11 dated						
	facility's follow-up sur	was conducted as part of the vey and complaint /29/18 to 05/31/18. Event						
	A revisit was conduct 05/31/18 and the faci compliance.							
{F 684} SS=D	Quality of Care CFR(s): 483.25		{F 6	84}			6/29/18	
	applies to all treatment facility residents. Bas assessment of a resident that residents receive accordance with profi- practice, the compre- care plan, and the resident This REQUIREMENT	ndamental principle that nt and care provided to ed on the comprehensive dent, the facility must ensure e treatment and care in essional standards of nensive person-centered						
		, event HCFX11 dated continued noncompliance at			Clear Creek Nursing and Rehab acknowledges receipt of the Statemen Deficiencies and proposes this Plan of Correction to the extent that the summ of findings is factually correct and in or 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 agreeme	ary der of		
		SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE	
Electroni	cally 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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/02/2019 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345562		B. WING			R-C 05/31/2018	
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR CF	REEK NURSING & REHA	BILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE INT HILL, NC 28227		
	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
{F 684}	Continued From page	2 1	{F 6	584}	 with the Statement of Deficiencies nor does it constitute an admission that an deficiency is accurate. Further, Clear Creek Nursing and Rehab reserves the right to refute any of the deficiencies of this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F684 Quality of Care The plan of correcting the specific deficiency. The plan should address th processes that led to the deficiency cit On 5/30/18, Clear Creek Nursing and Rehabilitation Center was placed into Immediate Jeopardy at 5:00 PM for fai 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 no report to a registered nurse (RN) for re-assessment of Resident #1 after receiving reports of the resident showin 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 (ME process of the resident showin signs of facian process of the resident showing specific deficiency cited On 5/10/18, the minimum data set (ME process of the resident showing specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific deficiency cited Desceptable plan of correction for the specific defi	e n ling ined it ng	
FORM CMS-256	7(02-99) Previous Versions Obs	olete Event ID:QM	N712	Fac	nurse's care plan – General Note	nuation shee	et Page 2 of 13

	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/02/2019 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
345562		B. WING		R-C 05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
CLEAR C	CLEAR CREEK NURSING & REHABILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE IINT HILL, NC 28227	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
{F 684}	Continued From page	2	{F 684}	 indicated Resident #1 was at baselined did not indicate Resident #1 with facial drooping or other change in condition On 5/11/18 earlier in the day before 1 AM, Nurse #1 did observe Resident # change in clarity of speech, but did not see any facial drooping or drooling, at then called the nurse practitioner to we the nurse practitioner would be at the facility on 5/11/18. Nurse #1 is a LPN 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 practition (NP) note indicated Resident #1 was by the NP. The NP note indicated "Patient seen for acute care. Meds, la notes reviewedalert, confusedUA reviewed, + for leukocytes, positive for nitratespatient refuses PO medicati give Rocephin 1 gram IM q24h x 3 do give with lidocaine." The NP note did indicate Resident #1 with right facial drooping. On 5/11/18 at approximately 1:00 PM restorative aide noticed Resident #1 is speech was not clear while weighing and took the resident to Nurse #1. On 5/11/18, at approximately 1:00 PM 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 	Al A

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 01/02/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562 B. WING			R-C 05/31/2018
NAME OF PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	•
CLEAR CREEK NURSING & REHABILITATION CENTER			10506 CLEAR CREEK COMMERCE DRIVI MINT HILL, NC 28227	E
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR	SHOULD BE COMPLETION
{F 684} Continued From page </td <td>≥3</td> <td>{F 68</td> <td> record. Not recognizing there were change of condition, LPN #1 dia a registered nurse (RN), NP, out (MD) to re-assess Resident #1 afternoon as the day progresses 5/11/18. On 5/11/18 at approximately 2: different resident's family member reported that she attempted to Nurse #1 regarding Resident # #1 stated she could not recall the visitor interaction. On 5/11/18 after 5:00 PM, the threported to Nurse #1 that Reside was exhibiting slouched postur and slurred speech. Nurse #1 NP assessed the resident in the and Resident #1 was on antibie for a urinary tract infection. On 5/11/18 at approximately 6: Nurse #1 administered an antibie injection for Resident #1. At the Nurse #1 did not note observine drooping or drooling. On 5/11/18 at the 7 PM shift che Nurse #1 reported to medicatio (MA) #1. Nurse #1 and MA #1 report to a RN Resident #1's che condition (right facial drooping, and continued slurred speech) assessment, failing to follow espolicy. On 5/12/18 at approximately 10 RN #1 assessed Resident #1. </td> <td>d not notify r physician in the ed on 45 PM, a ber approach 1. Nurse his specific therapist dent #1 e, drooling stated the e morning btic therapy 00 PM, biotic at time, g facial mange, on aide did not hange in drooling, for stablished</td>	≥3	{F 68	 record. Not recognizing there were change of condition, LPN #1 dia a registered nurse (RN), NP, out (MD) to re-assess Resident #1 afternoon as the day progresses 5/11/18. On 5/11/18 at approximately 2: different resident's family member reported that she attempted to Nurse #1 regarding Resident # #1 stated she could not recall the visitor interaction. On 5/11/18 after 5:00 PM, the threported to Nurse #1 that Reside was exhibiting slouched postur and slurred speech. Nurse #1 NP assessed the resident in the and Resident #1 was on antibie for a urinary tract infection. On 5/11/18 at approximately 6: Nurse #1 administered an antibie injection for Resident #1. At the Nurse #1 did not note observine drooping or drooling. On 5/11/18 at the 7 PM shift che Nurse #1 reported to medicatio (MA) #1. Nurse #1 and MA #1 report to a RN Resident #1's che condition (right facial drooping, and continued slurred speech) assessment, failing to follow espolicy. On 5/12/18 at approximately 10 RN #1 assessed Resident #1. 	d not notify r physician in the ed on 45 PM, a ber approach 1. Nurse his specific therapist dent #1 e, drooling stated the e morning btic therapy 00 PM, biotic at time, g facial mange, on aide did not hange in drooling, for stablished

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CENTER STATEMENT	S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	FOF OMB N (X3) DAT	ED: 01/02/2019 RM APPROVED IO. 0938-0391 TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER: A.		ING		COMPLETED	
		345562	B. WING	B. WING			R-C 5/31/2018
NAME OF P	ROVIDER OR SUPPLIER		•	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR C	REEK NURSING & REHA	BILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE INT HILL, NC 28227		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
{F 684}	Continued From page	÷4	{F 6	584}	assessment revealed Resident #1 had change in condition (right facial droop) RN #1 contacted Resident #1's physician/nurse practitioner provider. provider gave an order to send Reside #1 to the emergency department (ED) 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. RR met Resident #1 at the ED. The resident representative/daughter repo to the ED physician that Resident #1 v 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 laborat and radiology test results indicated no evidence that Resident #1 had a cerebrovascular (CVA), "Workup here far has been normal except the fact th she has been hypertensive, was also started on antibiotics for her urinary tra infections yesterday." On 5/12/18, physician orders were given to discha Resident #1 back to the facility with nor medications ordered. The discharge diagnoses of CVA, do not resuscitate (DNR), dementia, hyperlipidemia, and hypertension are listed on the hospital discharge summary. Resolved diagno included acute cystitis without hematu On 5/16/18, Resident #1 returned to th facility with a discharge instruction for hospice evaluation.	ng). The ent for #1 The tred vas ory so at act rge osis ria.	

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	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/02/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562		B. WING		R-C 05/31/2018
NAME OF P	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	
(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 APPI DEFICIENCY)	OULD BE COMPLETION
{F 684}	Continued From page	5	{F 684	4}	
				3. The monitoring procedure to that the plan of correction is effect that specific deficiency cited rema corrected and/or in compliance wire regulatory requirements	tive and ains
			On 5/30/18, the MDS RN and wor nurse RN assessed each resident RN assessment of each resident taking vital signs, pain, and menta for change in condition. The purp the assessment was to protect Re #1 and other residents in similar situations. The findings of the assessments: no current facility r have a new/previously unidentifie in condition requiring additional assessment or physician/NP notif On 5/30/18, the director of nursing initiated a re-education with all nu staff to include nursing assistants	t. The included al status pose of esident residents d change fication. g (DON) ursing 5 (NAs),	
				 MAs, LPNs, and RNs. The re-edu covered the topic of "Notification." "Notification of changes, Notification MD/NP and RP. When alerted of change in a resident, complete ar assessment and document. Reputed bruises of unknown origin" On 5/30/18, the facility administration DON consulted with the regional or president (RVP) and corporate factors of acility consultant re-educated the second secon	" ion of a a n orting own ator and vice cility ate

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/02/2019 MAPPROVED D. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED R-C	
		345562	B. WING				/31/2018	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
CLEAR C	REEK NURSING & REHA	BILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE IINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
{F 684}	Continued From page	2.6	{F 6	\$84}	administrator and DON. The re-educa covered the topics of Quality of Care a the requirements for Notification of Changes. In addition, the RVP and corporate facility consultant reviewed the administrator and DON topics of: Change in Condition policy, 3) failure assess for change of condition resultin from failure to follow established polic and 4) the importance of addressing resident/family concerns related to qui of care. On 5/30/18, the corporate facility consultant initiated a 100% audit of the nurse progress notes from 5/1/18 thro 5/30/18. The purpose of the audit was identify any needed resident assessm for Resident #1 or other resident at ris a change of condition that has not bee assessed and addressed through physician/NP provider notification and notification. Any resident needing assessment will be assessed by a RN notifications made to the care provide and RR. On 6/22/18, the corporate facility consultant re-educated the Interdisciplinary Team (IDT)- that inclu- but not limited to the DON, Staff Development Coordinator (SDC), treatment nurse, MDS Nurse, unit manager, activity director, rehab representative and social services- on morning clinical meeting format, and follow up items process. Newly hired I members will receive training on the morning clinical meeting during orients	and with 1) to ng y, ality e ugh s to ent k of en RR and r ndes the DT		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM APPROVED 50RM 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
345562 B. WI			B. WING _			R-C 05/31/2018
NAME OF P	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CIT	Y, STATE, ZIP CODE	
	REEK NURSING & REHA	BILITATION CENTER		10506 CLEAR CREEK	COMMERCE DRIVE	
				MINT HILL, NC 282	27	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIAT DEFICIENCY)	D.475
{F 684}	<pre>{F 684} Continued From page 7</pre>		(F 68	by the SDC. The nurse that is responsible f resident when a been identified. during a time w the licensed nu RN on call and The on-call RN	is assigned to the reside for the assessment of the a change of condition has . If the change occurs when a RN is not on duty irse or the MA will call the relay the pertinent data. will then be responsible the assessment of the	5
				the MAs, LPNs for assessment and notification extender and re Newly hired nu will receive the assessment an	e DON began to re-educa a, and RNs on the process t and change of condition to the physician, physici esident representative. rses and medications aid education on the ad change of condition an ing their orientation perio	s an les d
				clinical meeting from previous t determine pote in resident cond notification of p extender and re review will inclu orders, clinical intake, skin ale updates or revi family concerns any follow up it completion by e the daily IDT te	will review in morning the progress notes date o current meeting to intial changes of condition ditions to include ohysician and or physician esident representative. T ude copies of physician alerts that include meal rts, incidents, care plan sions, and resident and of s. The DON will documer ems that require end of day. The results of am meeting will be to the administrator.	ns h he or ht

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/02/2019 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562		B. WING _		R-C 05/31/2018
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	-
CLEAR CI	REEK NURSING & REHA	BILITATION CENTER		10506 CLEAR CREEK COMMERCE MINT HILL, NC 28227	DRIVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
{F 684}	Continued From page	28	{F 68	84}	
{F 867} SS=D	CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g)(2) The qu assurance committee (ii) Develop and imple action to correct ident This REQUIREMENT by: Based on observatio visitor, family, Nurse I Doctor interviews the Assessment and Asse	(ii) esessment and assurance. ality assessment and must: ement appropriate plans of tified quality deficiencies; is not met as evidenced ns, record review, staff, Practitioner, and Medical facility 's Quality urance Committee failed to	{F 84	 To maintain continued the follow-up items and comp submitted to the facility's of assurance/performance in Committee monthly for the quarterly for review and g additional issues are note will be addressed immedia corrective action taken. 4. The title of the person implementing the accepta correction. The administrator will be i and is responsible for imp acceptable plan of correct 67 F 867 QAPI Committee The plan of correcting the deficiency 	Appl (quality mprovement) ree months then uidance. If ed, those issues ately and responsible for able plan of implementing blementing the tion. 6/29/18
		d procedures and monitor at the committee put into lowing the facility ' s		The position of Clear Crea Rehabilitation center rega	

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/02/2019 M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		CONSTRUCTION	COMF	E SURVEY PLETED
		345562	B. WING				R-C / 31/2018
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	REEK NURSING & REHA			10	0506 CLEAR CREEK COMMERCE DRIVE		
	CER NORSING & REHA	BILITATION CENTER		м	IINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
{F 867}	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		{F 8	367}	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 th purpose and function of the QAPI Committee and review on-going compliance issues. The Administrator director of nursing (DON), minimum da set (MDS) nurse, staff facilitator, maintenance director, dietary manage activities director, quality improvement (QI) nurse and housekeeping supervisi will attend monthly and quarterly QAP committee meetings on an ongoing bac	y ne ata r, t sor I asis	
	#48). An interview was con Administrator on 05/3 Administrator stated h a couple of months an Assessment (QA) me was held monthly and Administrator, Director heads, medical direct pharmacist, and Regi Administrator explain	1/18 at 6:38 PM. The ne had been at the facility for nd he oversaw the Quality eeting. He explained that it d consisted of the or of Nursing, all department for, nurse practitioner,			and will assign additional team membras appropriate. On 6/20/18, the facility quarterly Exect QAPI Committee held a meeting to rethe tags from the most recent survey a go over the general plan of correcting deficiencies with the medical director a corporate facility consultant. On 6/20/18, the corporate facility consultant in-serviced the outgoing administrator and oncoming administrator and oncoming administrator and service functioning of the appropriate function of the appropria	utive view and the and and	

Facility ID: 070226

TATEMENT	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		345562	B. WING	R-C 05/31/2018	
NAME OF PROVIDER OR SUPPLIER		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR CREEK NURSING & 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 APPROI DEFICIENCY)	D BE COMPLETION
{F 867}	audits and monitoring that the audits were g holding all staff even so that the facility cou they want. The Admir ad hoc meetings as n a soft spot or area of together and discuss often they will seek th Director. The Adminis be meeting with his te	rvey and discussed how the tools were going. He added going well and he was weekend staff accountable uld achieving the compliance histrator added that they hold heeded if the team identity 's concern the team will come the issue. He added that he advice of the Medical strator stated that he would eam soon to discuss the formulate a plan that would	{F 867}	 the Executive QAPI Committee and purpose of the committee to include identifying issues and correct repear deficiencies related to F 684. On 6/20/18, the administrator in-ser the department heads related to the appropriate functioning of the QAPI committees and the purpose of the committees to include identifying iss and correct repeat deficiencies relate F684. As of 6/20/18 after the facility consulin-service, the facility QAPI committees for example: review of rour tools, review of work orders, review Point Click Care (electronic health record), review of resident concern review of pharmacy reports, and review of pharmacy reports, and review of pharmacy reports, and review committee will meet a minimum of quarterly to identify issues related to quality care, quality of life, safety, the analysis, and will develop and imple systematic corrective actions plans identified facility concerns. 	t viced sues red to ltant ee will ity nds of logs, view of QAPI o ends, ement for r the

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/02/2019 M APPROVED D. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345562	B. WING			R-C 05/31/2018		
NAME OF PROVIDER OR SUPPLIER				ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
	REEK NURSING & REHA	BILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIV				
				M	IINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
{F 867}	Continued From page	≥ 11	{F 8	367}	The monitoring procedure to ensure the the plan of correction is effective and to specific deficiency cited remains corre- and/or in compliance with the regulator requirements The Executive QAPI Committee which includes but is not limited to the Administrator, Medical Director, Qualit Improvement Coordinator, Social Wort 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, so services and general resident and fam satisfaction. The QAPI committee whi includes but is not limited to the Administrator, Director of Nursing, Soc Services, Activity Director, Infection Control Nurse, Maintenance Director, Housekeeping Supervisor and other st members as assigned by the Administrator. The QAPI committee with continue to meet monthly to discuss the QI Program progress that is centered of the needs and desires of our resident. The QAPI Committee reviews progress the standing QI committees with overses by a corporate staff member. The Executive QAPI Committee, include the medical director, will review quarter compiled QAPI report information, revi- trends, and review corrective actions taken and the dates of completion. The	hat cted ry y ker, cial ily ch cial ch cial taff ill ie on s of ight ding rly iew		

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Facility ID: 070226

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/02/201 1 APPROVE 0. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345562	B. WING			R-C 05/31/2018		
NAME OF PF	ROVIDER OR SUPPLIER		•	SI	TREET ADDRESS, CITY, STATE, ZIP CODE			
CLEAR CREEK NURSING & REHABILITATION CENTER					D506 CLEAR CREEK COMMERCE DRIVE			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		N (X5)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	COMPLETION DATE	
{F 867}	Continued From page 12		(F 8	8673				
(, , , , , , , , , , , , , , , , , , ,			ί C		Executive QAPI Committee will validat the facility's progress in correction of deficient practices or identify concerns The administrator will be responsible f ensuring committee concerns are addressed through further training or other interventions.	i.		
					The title of the person responsible for implementing the acceptable plan of correction			
					The administrator is responsible for implementation of the acceptable plan correction.	of		

Facility ID: 070226

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