PRINTED: 08/04/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345562	B. WING _			C 07/13/2023
NAME OF PI	ROVIDER OR SUPPLIER	0.0002		STREET ADDRESS, CITY, STATE, ZIP CODE		07/13/2023
CLEAR CI	REEK NURSING & REHA	BILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIV MINT HILL, NC 28227	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 0	00		
F 550	from 7/11/23 through The following intakes NC00203566, NC002 of the 11 complaint al deficiency. Resident Rights/Exer	00582 and NC00200676. 5 legations resulted in a cise of Rights	F 5	50		8/10/23
SS=G	§483.10(a) Resident The resident has a rig self-determination, ar access to persons an	Rights. Int to a dignified existence, Ind communication with and				
	with respect and dign resident in a manner promotes maintenand	and in an environment that be or enhancement of his or ognizing each resident's ity must protect and				
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal eregardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.				
		right to exercise his or her the facility and as a citizen				
ADODATODY	NIDECTORIS OR REQUIRER/S	SUPPLIER REPRESENTATIVE'S SIGNATUE		TITI F		(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.

08/02/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345562	B. WING		C 07/13/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01713/2023	
CLEAR CF	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 550	Continued From page	e 1	F 550			
	§483.10(b)(1) The factoresident can exercise	cility must ensure that the his or her rights without a, discrimination, or reprisal				
	free of interference, or reprisal from the facility rights and to be supplexercise of his or her subpart. This REQUIREMENT by: Based on record reviand staff interviews, to a resident's dignity by care. Resident #3 stamad. This occurred for dignity (Resident #3 the findings included Resident #3 was adm 9/20/21. Resident #3's quarter 4/28/23 revealed she refusal of care occurrance assistance with bed in use. She was always bladder. During a continuous of 11:38 am to 12:51 pronducted with Resident in the findings included the refusal of care occurrance assistance with bed in use. She was always bladder.	itted to the facility on If Minimum Data Set dated was cognitively intact with ing 1 to 3 days during the She required extensive nobility, transfers, and toilet incontinent of bowel and		The statements included are not an admission and do not constitute agreement with the alleged deficiencie herein. The plan of correction is completed in the compliance of state a federal regulations as outlined. To rem in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center □s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F550 1. What corrective action will be accomplished for each resident found have been affected by the deficient practice: Resident #3 stated it makes her frustrated when she is left to sit in wet brief for so long without help as staff and the state of the st	nd nain g of	
	the surveyor to turn h	er call light on because she vet and needed her brief		aware she can not clean herself. Resident was provided incontinence care on		

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			71. 501251	_		، ا	c	
		345562	B. WING				13/2023	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	13/2023	
					0506 CLEAR CREEK COMMERCE DRIVE			
CLEAR C	REEK NURSING & REHA	ABILITATION CENTER			IINT HILL, NC 28227			
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F 550	Continued From page	e 2	F	550				
		3 looked at the clock on the	•	000	7/11/2023. Resident #3 remains in the			
		long it would take staff to			facility and is provided timely incontine	nce		
	_	At 11:51 am, Resident #3's			care.	100		
		while Nurse Aide (NA) #1			Gare.			
	_	erved passing by the room			2. How corrective action will be			
		e call light. At 11:49 am,			accomplished for those residents havir	ıa		
		past the call light without			the potential to be affected by the same			
		am, another nurse aide			deficient practice:			
		g past the call light twice			·			
	while delivering water	while delivering water to other rooms in the hall.			Current residents will be interviewed by	/		
	At 12:37 pm, NA #1 v	valked into Resident #3's			Director of Nursing (DON), Assistant			
		room and asked the resident what she needed. Director of Nursing (ADON), Unit Manager		-				
		I'm wet and I need to be			(UM), Social Worker (SW), Minimal Da	ta		
	_	ned off the call light and			Set (MDS) and/or Nurse(s) regarding			
		that she had to get linen			dignity and respect using resident			
		clean up the resident. At			questionnaire by 8/10/2023. Residents			
		#2 entered Resident #3's			able to complete the questionnaire will			
		ident #3 how she was doing			have the clinical nursing management	£ 4 -		
		ything. Resident #3 stated eded to be cleaned up.			team physically check the resident brie ensure the resident is clean and dry. If			
		on the call light and left the			resident is not, assistance will be provi			
		NA #2 and NA #3 entered			immediately. This will be completed by			
	-	At this time, there was a			8/10/23.			
		which could be smelled from			0/10/20.			
	_	nt #3 stated to NA #2 and NA			3. Measures to be put in place or			
		and needed to be changed.			systemic changes made to ensure			
		esident to the bathroom by			practice will not re-occur:			
	wheelchair. They place	ced a clean brief and pants						
	on Resident #3. Res	ident #3 was assisted back			" Director of Nursing (DON), Assista	ınt		
	to her wheelchair. N	A #2 stated she was making			Director of Nursing (ADON), Unit Mana	ger		
		as assisting her. NA#3			(UM) will provide education to current			
		ad refused a shower at 11:00			contract agency/ facility nursing staff			
	_	ed to help with her care but			regarding resident rights and dignity ar	ı d		
		ent #3 had turned on her call			what constitutes dignity with examples			
	light.				including being in soiled brief for an			
	A fallance ! t !	7/44/22 -4 4.02			extended period of time by 8/10/2023.			
		on 7/11/23 at 1:00 pm with			After 8/10/2023, all contracted	7		
	shower at 11:00 am b	I she had refused to take a			agency/facility staff that has not worked and received the education will comple			
	SHOWEL ALTI.UU AIII L	701 3115 UIU 11UL 151U3C	1		L and received the education will comple	i C		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	Ē		
CLEAR CE	REEK NURSING & REH	ARII ITATION CENTER		10506 CLEAR CREEK COMMERCE DRIV	/E		
CLLANCI	KEEK NOKSING & KEII	ABILITATION CENTER		MINT HILL, NC 28227			
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F 550	Continued From pag	e 3	F 55	0			
F 550	incontinence care. A wet and needed to b stated she looked at was how she kept up stated it made her from her sit in a wet brief. Frustrated when they without helping me, to myself." An interview with NA revealed she was as #3. NA #2 stated that with rounds so they on NA #2 stated she had am to Resident #3 worden. She stated that resident needed income and she did not ask to be changed. An interview on 7/11, revealed she had as completed care roundshe had refused care stated she did not know the receive incontinence.	At 11:00 am, she was already e changed. Resident #3 the clock on the wall which o with the time. Resident #3 ustrated when the staff let She stated, "It makes me leave me sitting so long they know I can't do it with the time in the staff let She stated, at 1:10 pm signed to care for Resident at NA #3 had assisted her could get finished quicker. It do ffered a shower at 11:00 the refused so she left the at she was not aware the continence care at that time, Resident #3 if she needed to with Resident #3 since the at 11:00 am. Nurse #2 how Resident #3 did not	F 55	upon their next scheduled shift "Staff Development Coord will include education regardir rights and dignity and what co dignity with examples includin soiled brief for an extended pe in general orientation for contr agency/facility nursing staff. "Director of Nursing (DON Director of Nursing (ADON), L (UM), Social Worker (SW), Mi Set (MDS), Nurse(s) will inten- residents using questionnaire week x 4 weeks, weekly x4 we then monthly x1. Additionally, residents will be audited by th nursing management team by checking the resident brief to resident is clean and dry. If the not, assistance will be provide immediately, to ensure reside receiving incontinence care tir a week x 4 weeks, weekly x 4 then monthly x 1 month. 4. How facility will monitor c action(s) to ensure deficient p not re-occur:	inator (SDC) ng resident institutes g being in a eriod of time ract), Assistant Unit Manager nimal Data view 10% of 2 times a eeks, and 10% of e clinical physically ensure the e resident is ed ints are mely 2 times weeks, and orrective		
	revealed when she v #3's call light, she co Resident #3 had war Resident #3 had ask stated she got tied u water and she didn't room. NA #1 stated Resident #3 and only	vent in to answer Resident ouldn't remember what		The Administrator is responsite plan of correction and monitor and interview responses. The the audits and interviews will be weekly x4 weeks then monthly for completion and to ensure a concern are addressed. The CAssurance Performance Impro (QAPI) committee will meet months and review the audits	ring audits results of the reviewed by x 1 month all areas of Quality by ement conthly for 2		

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	01/13/2023
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F 561 SS=D	Resident #3 reveale room to answer her changed because shall she never asked for Resident #3 demons during the interview face turned red, and said, "I have trouble get mad." She added An interview was come as with the Director stated that anyone of the DON stated Resident waited more than an provided incontinent whoever answered have provided incontinent were doing another were doing another were doing another were doing another self-Determination CFR(s): 483.10(f)(1) \$483.10(f) Self-deted The resident has the promote and facilitated through support of root limited to the rigid (1) through (11) of the \$483.10(f)(1) The reactivities, schedules waking times), healt care services consists.	on 7/11/23 at 2:55 pm with d when NA #1 came to her call light, she had asked to be ne was "soaking wet" and that some water from NA #1. strated increased anger by wringing her hands, her she began to stutter. She getting my words out when I ed, "They knew I was wet." Inducted on 7/12/23 at 11:05 of Nursing (DON). The DON could answer the call lights. Sident #3 should not have a hour before she was be care. She also stated that Resident #3's call light should tinence care to her or should staff member to do it if they task at that time. Inducted on 7/12/23 at 11:05 of Nursing (DON). The DON could answer the call lights. Sident #3 should not have a hour before she was be care. She also stated that Resident #3's call light should tinence care to her or should staff member to do it if they task at that time. Inducted on 7/12/23 at 11:05 of Nursing (DON). The DON could answer the call lights. Sident #3 should not have a second that the care and the facility must be care. She also stated that the second that	F 58	interview responses to determine and/or further problem resolution in needed. Date of compliance: 8/10/2023.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ABILITATION CENTER	10506 CL		TREET ADDRESS, CITY, STATE, ZIP CODE 0506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	1 07/13/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 561	Continued From pag §483.10(f)(2) The re-	e 5 sident has a right to make	F	561			
	choices about aspect facility that are signif	ts of his or her life in the icant to the resident.					
	with members of the	sident has a right to interact community and participate in both inside and outside the					
	religious, and comminterfere with the right facility.	sident has a right to ctivities, including social, unity activities that do not nts of other residents in the T is not met as evidenced					
	by: Based on observation family member and sometimes failed to provide the	ons, record review, resident, staff interviews, the facility preferred type of bathing for sident #4 and Resident #2)			F561 1. What corrective action will be accomplished for each resident found thave been affected by the deficient	o	
	6/7/22 with diagnose	d: admitted to the facility on as that included chronic ulcer d peripheral vascular disease.			practice: Resident #2 was provided with their preferred type of bathing (shower) on 7/13/23. Resident #2 currently remains the facility and is receiving preferred ty of bath as scheduled. Resident #4 was provided with their		
	had intact cognition, care behaviors, was persons for bathing a	/5/23 indicated Resident #4 did not exhibit rejection of totally dependent on two and had impairment to one			preferred type of bath (shower) on 7/17/23. Resident #4 currently remains the facility and is receiving preferred ty of bath as scheduled.		
	7/5/23 indicated that	the lower extremities. #4's care plan reviewed on Resident #4 had potential for sychosocial adjustment			How corrective action will be accomplished for those residents havir the potential to be affected by the same deficient practice:	-	

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NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATI	E, ZIP CODE	1 0771072020	
			10506 CLEAR CREEK COMMERCE DRIV		ERCE DRIVE		
CLEAR CF	REEK NURSING & REHA	ABILITATION CENTER	MINT HILL, NC 28227				
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F 561	Continued From page	e 6	F 5	661			
	and customary routin allow resident input ir Resident #4 did not h of care.	change in resident's usual es. Interventions included to nto daily care and schedules. have a care plan for refusal		Current residents an parties will be intervied Nursing (DON), Assist Nursing (ADON), Unit Social Worker (SW), (MDS) Nurse(s), Activate determine the resident	ewed by Director of stant Director of it Manager (UM), Minimal Data Set vities Director to	of	
	#4 preferred to have	schedule indicated Resident showers two times a week saturday on the evening shift AM.		determine the resider party's preferred type resident. This informa the resident care guid	e of bath for the ation will be added		
	The Documentation Survey Reports for May, June and July 2023 indicated the following information regarding the type of bath Resident #4 received: May 2023 - Resident #4 was documented to have received no showers, partial bed baths on 5/6/23, 5/10/23, 5/13/23 and 5/24/23 and a full bed bath on 5/31/23. Resident #4 refused a shower on 5/10/23.			Measures to be practice will not re-oc	ade to ensure		
				Director of Nursing (A (UM) will provide edu contract agency/ facil therapy staff regardin offered and receiving	ication to current lity nursing staff and ig residents being their preferred type	ger nd pe	
	have received no sho 6/7/23 and 6/28/23. I shower on 6/19/23.	t #4 was documented to owers and a full bed bath on Resident #4 refused a		of bath. If resident ref type of bath, the resident will document the refutype of bath in the ele record. Education will	dent's assigned nu usal of the preferro ectronic health I be completed by	irse ed	
	received no showers and a partial bed bath	#4 was documented to have a full bed bath on 7/1/23 on 7/5/23 and 7/12/23.		8/6/2023. After 8/6/20 agency/facility staff the and received the edu upon their next sched	nat has not worked cation will comple duled shift.	te	
	day, but she preferred Resident #4 stated shat shower twice a week asked the staff if shethey often told her the her. Resident #4 state	AM, an interview with I she got a bed bath every I to take a shower instead. The was supposed to receive Ek. She stated that she had Could have a shower and The next shift would give it to The week when the evening shift The short shift has they were		will include education offered and receiving of bath and requirementation of refu orientation for contraction ursing staff.	their preferred typents for usals in general ct agency/facility	nt	

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		345562	B. WING				C
NAME OF B	201/1050 00 01 1001 150	343302	B: *******		TREET ARRESTS OF VICTOR THE TIP CORE	07/	/13/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CLEAR C	REEK NURSING & REH	ABILITATION CENTER			0506 CLEAR CREEK COMMERCE DRIVE		
				M	IINT HILL, NC 28227		
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F 561	Continued From pag	ge 7	F t	561			
	too busy to give her	a shower. During the			(UM), will complete audits of		
		#4 looked clean, did not have			documentation in the electronic health		
		not have any body odor.			record to identify any resident not		
	,	, ,			receiving their preferred type of bath.		
	A phone interview wi	ith Nurse Aide (NA) #6 on			Documentation audits will be conducte	d 3	
		revealed she worked with			times per week x 4 weeks, 1 time a we		
		on the night shift. NA #6			x 4 weeks, then monthly x1. Additional		
		ve Resident #4 a shower on			residents with BIMS of 12 or higher wil		
		er day because no one had			interviewed weekly to ensure they are		
	ever told her to do so, and she wasn't familiar				being offered their preferred type of ba	th.	
	with the shower sche	edule.					
					4. How facility will monitor corrective		
	A phone interview wi	ith NA #5 on 7/13/23 at 9:10			action(s) to ensure deficient practice w	ill	
	AM revealed she wo	orked with Resident #4 on			not re-occur:		
	7/5/23 on the night s	shift. NA #5 stated she did not					
		owers on her scheduled			The Administrator is responsible for the		
	_	se no one had ever told her			plan of correction and monitoring audit		
		sed to do so. NA #5 stated			and interview responses. The results o		
		any information about			the audits and interviews will be review		
		ntation when she started. NA			weekly x4 weeks then monthly x 1 mor		
		old by the staff to give the			for completion and to ensure all areas	of	
		so that's what she had been			concern are addressed. The Quality		
	doing.				Assurance Performance Improvement		
					(QAPI) committee will meet monthly fo	r 2	
	-	ith NA #7 on 7/13/23 at 10:19			months and review the audits and	1-	
		d worked with Resident #4 on			interview responses to determine trend	IS	
		shift. NA # 7 stated she did			and/or further problem resolution if		
		showers on her scheduled			needed.		
		se Resident #4 always s. NA #7 stated that Resident			Date of compliance: 9/40/2022		
					Date of compliance: 8/10/2023.		
		on the shower bed. NA#7 refused to take a shower on					
		e her a bed bath instead.					
	11 12/23 SU SHE gave	riici a peu patii Msteau.					
	A follow-up interview	with Resident #4 on 7/13/23					
		d Resident #4 did not get					
	offered a shower on	7/12/23. Resident #4 stated					
		er room and gave her a bed					
	bath. Resident #4 sta	ated she had never refused a					

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F 561	Continued From pa	ge 8	F 5	561		
F 501	shower and had ne afraid to use the sh that she liked the sl used the mechanic the shower bed. Re had been at the fac shower twice. On 7/13/23 at 1:50 Director of Nursing aware that Residen scheduled showers told her that Reside showers so the star another resident an #4 and see if she c #4 still refused the offer her a bed bath Resident #4 should showers based on 2. Resident #2 was 7/15/22 with diagnormal to the significant charset (MDS) assessing Resident #2 had mexhibited no rejection.	ver told anyone that she was ower bed. Resident #4 stated hower bed and that staff had al lift to get her from the bed to esident #4 stated since she sility, she had only received a PM, an interview with the (DON) revealed she was at #4 did not receive her at The DON stated staff had ent #4 always refused her ff would go and take care of all then come back to Resident shower, then the staff would in. The DON stated that a receive her scheduled	F	561		
	#2 was scheduled t	er schedule indicated Resident to have showers two times a ay and Saturday on the 7:00 PM to 7:00 AM.				
	June and July 2023	n Survey Reports for May, B indicated the following ng the type of bath Resident				

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	ROVIDER OR SUPPLIER	BILITATION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 0506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	<u>, </u>	13/2023	
(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 APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 561	received a full bed ba 5/11/23, 5/12/23, 5/13 5/25/23. No showers June 2023 - Resident have received a full be 6/7/23, 6/8/23, 6/15/26/22/23 and 6/26/23. documented. July 2023 - Resident received a shower or on 7/3/23, 7/6/23, 7/7 An interview was atte 7/11/23 at 10:00 AM surveyor and did not During an observation 7/12/23 at 8:25 AM, Nobserved checking R she was soiled. She check the brief and w #2's brief, Resident #closed Resident #2's would give Resident #2's would give Resident she hands before breakfat. NA #4 was hands before breakfat.	#2 was documented to have ath on 5/5/23, 5/8/23, 5/9/23, 5/15/23, 5/15/23 and were documented. #2 was documented to red bath on 6/5/23, 6/6/23, 3, 6/19/23, 6/20/23, 6/21/23, No showers were #2 was documented to have a 7/13/23 and a full bed bath at full bed bath at full bed bath answer any questions. ##2 on the care on Resident #2 on 7/12/23 was a bed bath after she at the care on Resident #2 on 7/12/23 was a full bed bath after she at the care on Resident #2 on 7/12/23 was a full bed bath after she at the care on Resident #2 on 7/12/23 was a full bed bath after she at the care on Resident #2 on 7/12/23 was a full bed bath after she at the care on Resident #2 on 7/12/23 was a full bed bath after she at the care on Resident #2 on 7/12/23 was a full bed bath after she at the care on Resident #2 on Res	F	561				

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		0.7	C / 13/2023	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 10506 CLEAR CREEK COMMERCE DR MINT HILL, NC 28227	DE	713/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 561	Continued From pag	ge 10	F 50	61			
	Resident #2's perind odor was noted after completed. An interview was confamily member on 7 family member states shower her unless sknew, they gave her asked them to. The had told the Director her that the night show shift nurse aide Resident #2 a show that Resident #2 ne	anducted with Resident #2's /13/23 at 9:17 AM. The ed that the staff would not she told them to and as far as a shower whenever she family member stated she of Nursing (DON) who told ift nurse aides and not the swere responsible for giving er. The family member stated eded to get her showers ways had problems with her					
	7/13/23 at 9:10 AM Resident #2 on the what date. NA #5 st #2 showers on her s because no one had #5 stated she had n about showers durir started, and she wa residents a bed bath doing. NA #5 stated shower schedule ar about this from the I She further stated th resident a shower o to 7:00 AM and that baths. A phone interview w	rith Nurse Aide (NA) #5 on revealed she had worked with night shift but did not recall ated she did not give Resident scheduled shower days dever told her to do so. NA ot received any information and orientation when she is told by the staff to give the in so that's what she had been dead had not received education Director of Nursing (DON). That she had never given any in the night shift from 7:00 PM is she had only been giving bed with Nurse Aide (NA) #6 on revealed she worked with					

		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
		345562	B. WING			C 07/13/2023	
NAME OF PR	ROVIDER OR SUPPLIER	0.0002		STREET ADDRESS, CITY, STATE, ZIP C	DDE	07/13/2023	
				10506 CLEAR CREEK COMMERCE D	RIVE		
CLEAR C	REEK NURSING & 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 PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 561	Continued From page	e 11	F 5	561			
F 677	Resident #2 on the ni 2023. NA #6 had give bath and a full bed ba stated she did not give her scheduled shower ever told her that she #6 stated that no one get Resident #2 up on NA #6 stated she was schedule and had not about it. NA #6 stated resident a shower on to 7:00 AM. An interview with the on 7/13/23 at 1:50 PN that Resident #2's far concerned about her DON stated that she son the showers and we continued to not receishowers. The DON stated that she was verbal in-service to the showers were not corremember if she had The DON stated Resicry and staff would trawere supposed to foll and give her a shower AM shift. The DON stated that #2 for night facility's schedule and preferred by Resident ADL Care Provided for	ght shift in June and July en Resident #2 a partial bed with but not a shower. NA #6 e Resident #2 showers on r days because no one had was supposed to do so. NA had ever told her to even ut of the bed until 7/12/23. Is not familiar with the shower to been educated by the DON d she had not given any the night shift from 7:00 Pm Director of Nursing (DON) If revealed she was aware mily member had been not receiving showers. The was currently doing audits was aware that Resident #2 ive any of her scheduled stated she had provided a ne night shift staff whenever mpleted but could not talked to NA #5 or NA #6. dent #2 sometimes would eat this as a refusal, but they ow the shower schedule r on her scheduled shower that Resident #2 was so on the 7:00 PM to 7:00 ated they had scheduled shift showers based on the		577		8/10/23	
	CFR(s): 483.24(a)(2)						

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			C 07/13/2023			
NAME OF PROVIDER OR SUPPLIER				STREET	ADDRESS, CITY, STATE, ZIP CODE	1 017	13/2023
	101.52.1.01.1.00.1.2.2.1				CLEAR CREEK COMMERCE DRIVE		
CLEAR CREEK NURSING & REHABILITATION CENTER					HILL, NC 28227		
	OLIMANA DV OT	ATEMENT OF REFIGIENCIES			<u> </u>		0.17)
(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 SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 12	F 6	77			
	out activities of daily I services to maintain of personal and oral hyd This REQUIREMENT by:	is not met as evidenced		F6	.77		
	and staff interviews, t dependent resident re when requested for 1	ew, observations, resident he facility failed to ensure a eceived incontinence care of 4 residents reviewed for ties of daily living (Resident		1. acc	What corrective action will be complished for each resident found to be been affected by the deficient actice:	to	
	obstructive pulmonar muscle weakness.	nitted to the facility on es that included chronic y disease (COPD) and		car in t car 2.	Resident #3 was provided incontine to on 7/11/2023. Resident #3 remain the facility and is provided incontine to when requested. How corrective action will be complished for those residents having the complished for those residents having the complished for those residents.	ns nce ng	
	weakness, and impai was incontinent and whistory of refusing inconstitutions showers, despite staff encouragement and eassociated with not have care. Interventions incontinence care after Resident #3's quarter 4/28/23 revealed she refusal of care occurr assessment period. Sassistance with bed in	activities of daily eficit related to COPD, red mobility. Resident #3 wore briefs. She had a ontinence care and f's continued education on the risk factors aving adequate incontinence cluded for Resident #3 to esist with toileting and er incontinent episodes. Ily Minimum Data Set dated was cognitively intact with ing 1 to 3 days during the She required extensive mobility, transfers, and toilet		Cui 12 Nui Soo (MI car 8/1 inte ma res clea	rrent residents with BIMS greater th will be interviewed by Director of rsing (DON), Assistant Director of rsing (ADON), Unit Manager (UM), cial Worker (SW), Minimal Data Set DS), Nurses ensuring incontinence is being provided when requested 0/2023. Residents not able to be erviewed will have the clinical nursin nagement team physically check the ident brief to ensure the resident is an and dry. If the resident is not, is stance will be provided immediated is will be completed by 8/10/23.	an I by ng e	
		incontinent of bowel and		3.	Measures to be put in place or		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		345562	B. WING			C	
	201/1252 05 01/1251 155	343362	B. WING		(7/13/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
CLEAR CREEK NURSING & REHABILITATION CENTER				10506 CLEAR CREEK COMMERCE DRIV	E		
				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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Continued From page	e 13	F 67	7			
	bladder.			systemic changes made to ens	ure		
	biaddor.			practice will not re-occur:	uic		
	During a continuous	observation on 7/11/23 from		practice will not re-occur.			
	11:38 am to 12:51 pn			Director of Nursing (DON)	Δeeietant		
		dent #3 who was sitting up in		Director of Nursing (ADON), U			
		oom. Resident #3 requested		(UM) will provide education to	-		
		ner call light on because she		contract agency/ facility nursing			
	•	vet and needed her brief		noting residents should receive	•		
		m, Resident #3's call light		incontinence care when reques			
		urse Aide (NA) #1 and NA #3		checked and changed several			
		ng by the room without		shift, if unable to communicate	•		
		ht. At 11:49 am, Therapist		for incontinence care by 8/10/2			
		all light without answering it.		8/10/2023, all contracted agen			
		nurse aide was observed		staff that has not worked and re	eceived the		
	walking past the call	light twice while delivering		education will complete upon the	neir next		
	water to other rooms	in the hall. At 12:37 pm, NA		scheduled shift.			
	#1 walked into Resid	ent #3's room and asked the		Staff Development Coording	nator (SDC)		
	resident what she ne	eded. Resident #3 stated,		will include education noting re	sidents		
	"I'm wet and I need to	be changed." NA #1		should receive incontinence ca	re when		
	turned off the call ligh	nt and stated to Resident #3		requested and be checked and	l changed		
	that she had to get lir	nen and would be back to		several times per shift, if unabl	e to		
		. At 12:45 pm, Therapist #2		communicate the need for inco	ntinence		
	entered Resident #3's	s room and asked Resident		care for contract agency/facility	/ nursing		
	#3 how she was doin	g and if she needed		staff in general orientation for o	ontract		
		3 stated she was wet and		agency/facility nursing staff.			
		d up. Therapist #2 turned on		Director of Nursing (DON)			
	•	the room. At 12:51 pm, NA		Director of Nursing (ADON), U	-		
		d Resident #3's room. At		(UM), Social Worker (SW), Mir			
		strong odor of urine which		Set (MDS), Nurse(s) will intervi			
		n the hallway. Resident #3		residents dependent for ADL ca			
		NA #3 that she was wet and		BIMS of 12 or higher to ensure			
	•	d. NA #2 assisted the		incontinence care is being prov			
		oom by wheelchair. Both		requested and be checked and	•		
		their hands and applied		several times per shift, if unabl			
		d the resident to the corner		communicate the need for inco			
		dent held onto the railing,		care 2 times a week x 4 weeks			
	-	If to a standing position. The		weeks, and then monthly x1. A	-		
		her wet pants before		10% of residents with BIMS les			
	removing her brief wh	nich was heavily soiled with		will be audited by the clinical n	ursing		

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	((X3) DATE SURVEY COMPLETED	
	345562 B. WING			C 07/13/2023		
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO	I DDE	01113/2023		
			10506 CLEAR CREEK COMMERCE D	RIVE		
CLEAR CREEK NURSING & REHABII	LITATION CENTER		MINT HILL, NC 28227			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES IUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT		
bottom revealed no red nurse aides cleaned it. and pants on Resident # assisted back to her who she was making rounds her. NA #3 stated Resid shower at 11:00 am and with her care but was not turned on her call light. A follow-up interview on Resident #3 revealed she shower at 11:00 am but incontinence care. At 1 wet and needed to be of stated she looked at the was how she kept up with the was how she kept up with the was how she was assign #3. NA #2 stated that NA rounds so they could ge stated she had offered at Resident #3 who refuses She stated that she was needed incontinence cated in the was needed incontinence cated in the was needed incontinence cated in the was needed incontinence cated the nurse had with her care rounds and Resident #3 had refused stated Resident #3 was	servation of Resident #3's or open areas after the They placed a clean brief #3. Resident #3 was eelchair. NA #2 stated and NA #3 was assisting dent #3 had refused a he had agreed to help of aware Resident #3 had 7/11/23 at 1:00 pm with the had refused to take a she did not refuse 1:00 am, she was already hanged. Resident #3 eclock on the wall and this ith the time. on 7/11/23 at 1:10 pm med to care for Resident A #3 had assisted her with the finished quicker. NA #2 a shower at 11:00 am to d so she left the room. In the she ware the resident are at that time, and she if she needed to be at 1:15 pm with NA #3 asked him to assist NA #2 d he was told that d care at 11:00 am. He an easy resident to e knew her call light had	F 6	management team by physisthe resident brief to ensure a clean and dry, 2 times a wew weekly x 4 weeks, and then month. If the resident is not, will be provided immediately 4. How facility will monitor action(s) to ensure deficient not re-occur: The Administrator is responsible plan of correction and monitiand interview responses. The audits and interviews wiweekly x4 weeks then mont for completion and to ensure concern are addressed. The Assurance Performance Implication (QAPI) committee will meet months and review the auditinterview responses to determine and/or further problem resoluted. Date of compliance: 8/10/20	the resident tek x 4 weeks monthly x 1, assistance y. It corrective the practice will assible for the toring audits the results of the toring audits the results of all areas of the equality provement monthly for this and termine trends lution if	is s, s, l	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		345562	B. WING _			C 07/13/2023	
NAME OF PROVIDER OR SUPPLIER CLEAR CREEK NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVI MINT HILL, NC 28227	·	01710/2023	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	revealed she had a completed care roushe had refused care roushe had refused castated she did not kereceive incontinence. An interview on 7/1 revealed when she #3's call light, she consider the state of the water and she didner room. NA #1 states and consider the state of the couldn't remember thanged. A follow-up interview Resident #3 revealer thanged because is she never asked for the changed because is she never asked for the call it because she probattention to it. The task-oriented and we something else whe #3's call light. An interview on 7/1 #2 revealed she we retrieve Resident #3 we retrieve Resident #3 when she spoke we receive incontinued and we retrieve Resident #3 when she spoke we receive incontinued and we retrieve Resident #3 when she spoke we receive incontinued and we retrieve Resident #3 when she spoke we receive incontinued and we retrieve Resident #3 when she spoke we receive incontinued and we retrieve Resident #3 when she spoke we receive incontinued and we retrieve Resident #3 when she spoke we receive incontinued and we receive inc	ge 15 1/23 at 2:40 pm with Nurse #2 sked NA #2 to make sure she nds with Resident #3 since re at 11:00 am. Nurse #2 know Resident #3 did not re care at 11:00 am. 1/23 at 1:46 pm with NA #1 went in to answer Resident couldn't remember what anted but she thought kked for some water. NA #1 up giving the other residents to come back to Resident #3's d she wasn't assigned to ally answered her call light, but aber Resident #3 requesting to w on 7/11/23 at 2:55 pm with red when NA #1 came to her reall light, she had asked to be she was "soaking wet" and that resome water from NA #1. 2/23 at 8:37 am with Therapist d walked by Resident #3's light was on but didn't answer ably did not see it or pay rapist #1 reported she was vas probably thinking of en she walked past Resident 2/23 at 1:40 pm with Therapist ent into Resident #3's room to 3's roommate's glasses. ith Resident #3, the resident eded to be changed.	F 6	77			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345562	B. WING			С
NAME OF PROVIDER OR SUPPLIER CLEAR CREEK NURSING & REHABILITATION CENTER			B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVI MINT HILL, NC 28227	•	07/13/2023
(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 CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 677	and spoke with a gronurse on the hall. The not remember who site them that Resident # changed. Therapist # staff informed her that take a shower early the was going back to change with the Director of stated that anyone control of the DON stated Reswaited more than an provided incontinence whoever answered Reshave provided incontinence.	on Resident #3's call light up of nurse aides and the erapist #2 stated she could ne talked to, but she told 3 had requested to be #2 further stated that the tt Resident #3 had refused to hat morning, but that staff eck on her. ducted on 7/12/23 at 11:05 of Nursing (DON). The DON ould answer the call lights. ident #3 should not have hour before she was e care. She also stated that esident #3's call light should inence care to her or should staff member to do it if they	F6	577		