STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562	A. BUILDING _____ B. WING _____	C 03/21/2025

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 03/17/25 through 03/21/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #34NF11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 03/17/25 through 03/21/25. Event ID# 34NF11. The following intakes were investigated NC00219307, NC00216661, NC00212808, NC00216557, NC00225997, NC00224043, NC00222495, NC00215333, NC00223719, NC00223687, and NC00225032. 1 of the 26 complaint allegations resulted in deficiency.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a	F 565		4/18/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/14/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 565	Continued From page 1 resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to provide resolution of Resident Council Meeting grievances for 4 of 6 monthly Resident Council Meetings. The Resident Council had concerns during resident council meetings that revealed no follow up resolutions (09/19/24, 11/14/24, 12/11/24, and 01/16/24.) The findings included: On 09/19/24 the Resident Council Meeting Minutes noted music not being played during meals, getting assistance to go to the beauty shop, and residents wants "DNR" above their bed. The Resident Council Follow-Up for 09/19/24 Resident Council Meeting Minutes did not	F 565	F565 Resident/Family Group and Response 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice? The Resident Council Meeting concerns on 9/19/24, 11/14/24, 12/11/24, and 1/16/24 will be followed up by the Social Service Director and the resolutions completed to include the facility's responses by 4/17/2025. The findings will be reviewed in resident council by the Activity Director. 2. What corrective action will be accomplished for those residents who	

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F 565	Continued From page 2 demonstrate the facility's response to grievances voiced during the Resident Council. On 11/14/24 the Resident Council Meeting Minutes noted call lights were not being answered. The Resident Council Follow-Up for 11/14/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 12/11/24 the Resident Council Meeting Minutes noted call lights were not being answered and residents had issues with different nursing staff. The Resident Council Follow-Up for 12/11/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. On 01/16/24 the Resident Council Meeting Minutes noted sink and toilet issues, missing laundry, resident rooms needing painting, nursing staff being loud at night, and call lights not being answered. The Resident Council Follow-Up for 01/16/24 Resident Council Meeting Minutes did not demonstrate the facility's response to grievances voiced during the Resident Council. Interviews conducted with Resident #4, Resident #13, Resident #49, and Resident #61 during the Resident Council Meeting on 03/20/25 at 11:00 AM revealed there had been no resolution with the ongoing concerns that were addressed during the resident council meetings. The residents	F 565	have the potential to be affected by the deficient practice? The current residents are at risk for this deficient practice. Resident Council Meeting minutes in the last 60 days will be reviewed by the Social Service Director by 4/17/2025 to ensure resident council concerns have been addressed and resolutions completed to ensure facility responses to resident concerns have been followed up. 3. What measures are to be put in place or systemic changes will be made to ensure the practice will not re-occur? The Administrator will educate the Interdisciplinary team to include Social Service Director, Activity Director, Maintenance Director, Therapy Director, Housekeeping Director and the Director of Nursing by 4/17/2025 related to ensuring Resident Council Grievances are being completed to include follow up facility response resolutions. New hire interdisciplinary team members will also receive this education during the facility orientation prior to working in the facility. 4. How will the facility monitor corrective action(s) to ensure that the deficient practice does not re-occur? The Activity Director will conduct Resident Council Meetings weekly x 4 weeks and then monthly to ensure resident concerns continue to be addressed and follow up resolutions are completed as required. The Administrator is responsible for the	

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F 565	Continued From page 3 further revealed the issues were still a concern and the Activity Director (AD) did not discuss resolutions at resident council meetings. An interview conducted with the Activity Director (AD) on 03/20/25 at 12:05 PM revealed he had completed grievances and gave them to department heads to follow up on. The AD further revealed once the department heads completed grievance that they were sent to the Administrator and Social Worker. The AD stated he had failed to document resolutions on resident council minutes, but had reported to the resident council residents how concerns were being addressed. An interview conducted with the facility Social Worker (SW) on 03/20/25 at 12:30 PM revealed when grievances are completed during resident council minutes they are signed off by the Administrator and brought to her to be stored. The SW further revealed she had not received any resident council grievances since August 2024. An interview conducted with the Administrator on 03/20/25 at 1:00 PM revealed he was not aware if grievances were being completed and resolved from Resident Council meetings. The Administrator further revealed he expected concerns to be addressed and documentation to be included within the Resident Council minutes.	F 565	plan of correction to ensure Resident Council Meeting concerns are addressed and follow up resolutions completed. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review the findings and trends to ensure continued compliance and/or revision if needed.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C	F 644		4/18/25

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F 644	Continued From page 4 of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) level II referral was made after a resident was given new mental health diagnoses for 1 of 3 residents (Resident #71) reviewed for PASRR. The findings include: Review of Resident #71's medical record revealed the resident was originally admitted to the facility on 04/18/23 and a PASRR level I was completed. The resident was diagnosed with depression on 04/20/23, delusional disorder on 12/4/23, and insomnia on 12/04/24. Review of Resident #71's most recent comprehensive Minimum Data Set (MDS) dated 08/21/24 revealed the resident was not coded for a level II PASRR.	F 644	F644 Coordination of PASARR and Assessments 1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #71 was diagnosed with depression on 4/20/23, delusional disorder on 12/4/23 and insomnia on 12/04/24. Social Worker has sent the level 2 Preadmission Screening and Resident Review (PASRR) referral on 3/17/2025. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: The current residents that require PASRR screenings are at risk for this deficient practice. Social Service will complete audits of	

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F 644	Continued From page 5 During an interview on 03/19/25 at 1:00 PM with the Social Worker (SW) she revealed a PASRR level II referral should be completed upon admission for residents with a mental health diagnosis and when a resident has had a change of condition or a newly added mental health diagnosis. It was further revealed by the SW Resident #71 should have been assessed for a possible level II and the facility failed to do so. The SW indicated she was not aware that Resident #71 did not have level II PASRR determination. During an interview on 03/20/25 at 1:00 PM with the Administrator he revealed PASRR level II referrals should be completed in a timely manner upon the admission of a resident with a mental health diagnosis or anytime a resident has had a change of condition or a newly added mental health diagnosis. The Administrator stated he was not aware Resident #71 had not been assessed for a possible PASRR level II.	F 644	current residents to ensure PASRR screenings are being completed as required by 3/17/2025. Any residents that are identified as needing a PASRR level 2 will be follow up by social services. 3. Address what measures will be put into place or systemic changes made to ensure that deficient practice will not recur: As of 4/7/2025 The Administrator re-educated the Social Worker on the PASARR screening and Submission process. Newly hired social workers will be required to complete this education during facility orientation prior to working. 4. Indicate how the facility plans to monitor its performance to ensure the deficient practice does not recur: The Social Worker will audits of at least 5 medical records of new admissions and residents with new diagnosis weekly x 8weeks and monthly x 1 month to ensure PASARR 2 screening assessments are being completed as required. The Social Worker is responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x 3 months to review audit results to determine trends and/or follow up if needed.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on	F 690		4/18/25

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F 690	Continued From page 6 admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff and Nurse Practitioner interviews, the facility failed to remove an indwelling urinary catheter per the physician's order and failed to keep a urinary catheter drainage bag and tubing from touching the floor to reduce the risk of infection for 1 of 4	F 690	F690 Bowel/Bladder Incontinence 1. What corrective action will be accomplished for each resident found to have been affected by the deficient practice?	

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F 690	Continued From page 7 residents reviewed for urinary catheters (Resident #36). The findings included: Resident #36 was admitted to the facility on 03/17/23 with diagnoses that included history of stage 3-4 pressure ulcer. The annual Minimum Data Set (MDS) assessment dated 12/19/24 indicated Resident #36 was moderately cognitively impaired and was coded for having an indwelling urinary catheter. The care plan dated 01/02/25 revealed Resident #36 had an indwelling urinary catheter due to a stage 4 sacral wound and the interventions included providing catheter care per the physician orders. Resident #36 had a physician order dated 03/11/25 that read; discontinue the indwelling urinary catheter on 03/15/25. The order was entered by Nurse #3. Resident #36's medication administration record (MAR) indicated the indwelling urinary catheter was removed on 03/15/25 by Nurse #6. a. An observation conducted on 03/17/25 at 10:21 AM revealed Resident #36 was lying in bed resting and had an indwelling urinary catheter draining to a bedside drainage bag. An interview with Nurse #3 on 03/19/25 at 12:20 PM revealed on 03/11/25 a member of the nurse management team, she did not recall their name, asked her to obtain a physician's order to remove Resident #36's indwelling urinary catheter. Nurse	F 690	Resident #36 catheter was removed on 3/17/2025. 2. What corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice. All residents with indwelling foley catheters have the potential to be affected by the deficient practice. The Director of Nursing/Designee will audit resident records with indwelling foley catheters to ensure the residents clinical condition indicates that catheterization is necessary. If not clinically indicated, an order will be obtained to remove catheter and completed timely per physician order by 4/17/2025. The Director of Nursing/Designee will audit all residents with indwelling foley catheter to ensure that the drainage bag is secured under the bed frame and/or wheelchair and not touching the floor by 4/17/2025. 3. Measures put in place or systemic changes made to ensure practice will not re-occur? The Staff Development Coordinator will complete education to licensed nursing staff by 4/17/2025 regarding ensuring that catheterization of a resident is clinically indicated prior to inserting a catheter and removed promptly upon receiving a physician order to discontinue catheter. The Director of Nursing/Designee will audit any new start catheterization or residents admitted with indwelling foley catheters for clinical indication of	

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F 690	Continued From page 8 #3 stated she called the Nurse Practitioner and obtained an order to remove Resident #36's indwelling urinary catheter on 03/15/25. Nurse #3 indicated she entered the order into the electronic medical record, but she was not Resident #36's assigned nurse on 03/15/25 and was unsure if the urinary catheter was removed. A phone interview with Nurse #6 on 03/20/25 at 8:04 AM indicated she was the 3rd shift (11pm-7am) nursing supervisor on 03/14/25 to 03/15/25. She indicated she did not recall seeing an order to remove Resident #36's indwelling urinary catheter on 03/15/25 nor did she remove the catheter. Nurse #6 was unable to explain why it was documented on the MAR that she completed the order to remove Resident #36's indwelling urinary catheter. During an interview with Nurse #5 on 03/20/25 at 9:03 AM she indicated she was Resident #36's assigned nurse on 3/17/25. Nurse #5 revealed a nurse, she did not recall her name, informed her that Resident #36 had an order to remove Resident #36's indwelling urinary catheter on 03/15/25 that was not completed. Nurse #5 stated she removed Resident #36's indwelling urinary catheter on 03/17/25 at approximately 10:30 AM. An interview conducted with the Nurse Practitioner (NP) on 03/19/25 at 10:16 AM revealed she received a phone call from the facility on 03/11/25 requesting an order to remove Resident #36's urinary catheter because there was not a supporting diagnosis for the use of the catheter. The NP indicated she ordered Resident #36's indwelling urinary catheter to be removed on 03/15/25. The NP stated she was unaware	F 690	necessity weekly x 3 months. If not indicated, an order will be obtained to discontinue the catheter and follow-up to ensure that the physician's order is completed timely. The Staff Development Coordinator will complete education to nursing staff regarding ensuring that the drainage bag is secured under the bed frame/wheelchair and not touching the floor by 4/17/2025. The Director of nursing will audit 3 residents with indwelling catheters per week x 3 months to ensure that they are properly secured under the bed frame/wheelchair and not touching the floor. 4. How will the facility monitor corrective action(s) to ensure deficient practice does not re-occur? The Administrator is responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x3 months to review audit results to determine trends and/or further problem resolution if needed.	

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F 690	Continued From page 9	F 690		

the order was not completed, and the catheter should have been removed on 03/15/25 as ordered.

During an interview with the Director of Nursing (DON) on 03/20/25 at 11:05 AM she revealed Resident #36 had an indwelling urinary catheter in place to assist with healing of a sacral wound. The DON indicated the interdisciplinary care team decided wound healing was not considered to be a supporting diagnosis for the use of an indwelling urinary catheter, so they requested an order from the NP to remove the catheter. The DON indicated she was not aware Resident #36's indwelling urinary catheter was not removed on the order date and that it should have been removed on 03/15/25 as ordered.

An interview conducted with the Administrator on 03/20/25 at 1:30 PM indicated an order to remove an indwelling urinary catheter should have been completed on the date the physician ordered it to be removed.

b. An observation conducted on 03/17/25 at 10:21 AM revealed Resident #36 was lying in bed resting and had an indwelling urinary catheter draining to a bedside drainage bag. The catheter tubing and bedside drainage bag were observed lying on the floor beside the bed.

An interview with Nurse #5 on 03/17/25 at 10:51 AM indicated she was assigned to Resident #36 and entered her room around 10:30 AM to remove the indwelling urinary catheter. She stated the catheter tubing and bedside drainage bag were lying on the floor beside the bed. Nurse #5 indicated the Nurse Aides (NA) were responsible for emptying the bedside drainage

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F 690	Continued From page 10 bags and usually emptied them at the end of each shift. Nurse #5 was unsure if the drainage bag lying on the floor was last emptied by the 3rd shift NA or the 1st shift NA, but stated it should have been secured under the bed frame and not touching the floor. A phone interview with NA #5 on 03/20/25 at 1:53 PM revealed she was the 3rd shift NA assigned to Resident #36 on 03/16/25. NA #5 stated she emptied Resident #36's bedside drainage bag around 6:00 AM on 03/17/25 prior to the end of her shift and then secured the drainage bag under the bed frame to ensure it was not touching the floor. NA #5 stated when she left Resident #36's room the urinary catheter tubing and bedside drainage bag were not touching the floor. Several attempts were made to contact NA #4, assigned to Resident #36 on 1st shift on 03/17/25, were unsuccessful. An interview conducted with the Director of Nursing on 03/20/25 at 11:05 AM revealed indwelling urinary catheter tubing and bedside drainage bags should be secured under the bed frame when a resident was in bed and not touching the floor. The DON indicated catheter tubing and drainage bags should not be lying on the floor because of the increased risk of infection. During an interview with the Administrator on 03/20/25 at 1:30 PM he stated urinary catheter tubing and drainage bags should not be lying on the floor due to the increased risk for infection.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		4/18/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 11 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and family member and staff interviews, the facility failed to obtain a physician order for oxygen therapy for 1 of 1 resident reviewed for respiratory care (Resident #72). The findings included: Resident #72 was admitted to the facility 1/18/25 with diagnoses including chronic lung disease and hypertension. The admission Minimum Data Set (MDS) assessment dated 1/25/25 assessed Resident #72 to have oxygen therapy. A physician order dated 1/18/25 read "(for) cyanosis or dyspnea: oxygen at 2 liters per minute, notify the provider." A care plan dated 1/21/25 addressed Resident #72's potential for breathing issues related to his lung disease and specified to administer oxygen at 2 liters per minute by nasal canula. Review of the physician orders for Resident #72 revealed no order for oxygen therapy.	F 695	F695 Respiratory/Tracheostomy Care and Suctioning 1. What corrective action will be accomplished for each resident found to be affected by the deficient practice? A physician's order for oxygen, including flow rate was obtained for resident #72 on 3/19/2015 by The Unit Manager, and an order to change oxygen tubing weekly on 3/23/2025 by Unit Manager. 2. What corrective action will be accomplished for those residents who have the potential to be affected by the same deficient practice? All residents that require oxygen therapy are at risk for this deficient practice. The Director of Nursing/designee will audit all residents that require oxygen therapy to ensure that physician orders are in place by 4/17/25. 3. What measures are to be put in place or systemic changes will be made to ensure the practice will not re-occur? The staff development coordinator will	

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	345562	A. BUILDING _____ B. WING _____	C 03/21/2025

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F 695	Continued From page 12 The significant change MDS dated 2/26/25 assessed Resident #72 to not have oxygen therapy. Resident #72 was observed on 3/17/25 at 2:16 PM. Resident #72 had an oxygen concentrator running at the bedside, delivering 2.5 liters of oxygen by nasal cannula. The Responsible Party was interviewed at the time of the observation, and he reported Resident #72 required oxygen all the time because of his lung disease and he had been receiving oxygen therapy since he was admitted to the facility. Resident #72 was observed on 3/19/25 at 12:50 PM. The oxygen concentrator was running at the bedside, delivering 3 liters of oxygen by nasal cannula. The Nurse Practitioner was interviewed on 3/19/25 at 10:32 AM and she reported she was aware Resident #72 was using oxygen, but did not know there was not an active order for oxygen therapy. Nurse #4 was interviewed on 3/19/25 at 12:55 PM and she checked the physician orders for oxygen for Resident #72 and was unable to find an order for oxygen. Nurse #4 reported Resident #72 should have a physician order for oxygen and the order for oxygen would give instructions for the flowrate, as well as changing the nasal cannula and oxygen tubing. The Director of Nursing was interviewed on 3/20/25 at 10:55 AM and she reported she was not aware there was no order for oxygen for Resident #72 and there should be an order with	F 695	complete education with the licensed nurses related to ensuring that residents that are receiving oxygen therapy have physician orders by 4/17/2025. The new hired licensed nurses will receive this education during the facility orientation prior to working. The Director of Nursing/Designee will audit 5 residents weekly for 4 weeks and monthly x 2 to ensure residents that require oxygen therapy have physician orders. 4. How will the facility monitor corrective action(s) to ensure deficient practice will not re-occur? The Administrator is responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 3 months and review audits to determine trend and/or follow up if needed.	

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F 695	Continued From page 13 the flowrate and orders to change the tubing and nasal cannula. The DON explained initiating oxygen therapy was a nursing judgement, but the physician needed to be notified to write an order.	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a performance review every 12 months for 2 of 5 Nurse Aides (NAs) reviewed to ensure in-service education was designed to address the outcome of the performance evaluations (NA #2 and NA #3). The findings included: a. A review of NA #3's employment file revealed a hire date of 8/27/21. There was no record a performance review was completed for NA #3 from January 2024 to present. A phone interview conducted with NA #3 on 3/21/25 at 10:22 AM indicated she did not recall that a performance review had been completed at any time during her employment at the facility. b. A review of NA #2's employment file revealed a hire date of 5/30/23. There was no record a performance review was completed for NA #2	F 730	F730 Nurse Aide Perform Review-12Hr/yr In-Service 1. What corrective action will be accomplished for each staff member found to have been affected by the deficient practice? NA #2 and NA#3 had performance reviews completed by 4/17/2025 by the Assistant Director of Nursing. 2. What corrective action will be accomplished for those staff who have the potential to be affected by the same deficient practice? All current residents are at risk for this deficient practice. The Staff Development Coordinator (SDC)/Designee will complete an audit of all the certified nursing assistants to ensure a performance review has been completed within the last 12 months. Any identified certified nursing assistants who	4/18/25

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F 730	Continued From page 14 from January 2024 to present. A phone interview with NA #2 on 3/21/25 at 10:02 AM indicated she did not recall that a performance review had been completed since she was hired by the facility in 2023. A phone interview conducted with the Staff Development Coordinator (SDC) on 3/21/25 at 10:50 AM revealed she started working as the facility's SDC in August of 2024. The SDC stated the NA annual performance reviews were a part of the facility's online education program and email notifications were sent to the NAs when the performance review was due, and she received the email as well. The SDC stated she provided reminders to the NAs when the performance review was due, but the NA was responsible for printing the review, having it completed by a nurse and then providing a copy of the review for her to keep on file. The SDC revealed she did not recall receiving email notifications that NA #2 and NA #3 were due for a performance review and was unable to explain why there was no record that a performance review was completed for NA #2 and NA #3 every 12 months as required. Attempts made to contact the former SDC were unsuccessful. A phone interview with the Director of Nursing on 3/21/25 at 11:21 AM indicated the SDC was responsible for monitoring the completion of the NA performance reviews and NA performance reviews should be completed every 12 months. A phone interview with the Administrator on 03/21/25 at 11:21 AM revealed NAs should have	F 730	have not completed the required performance reviews, the SDC will ensure that they care completed by 4/17/2025. 3. Measures put in place or systemic changes made to ensure practice will not re-occur? The Staff Development Coordinator/Designee will complete an audit of 5 licensed staff members' file weekly x 1 month, then 3 licensed staff members file weekly x 2 months to ensure that performance reviews continue to be completed every 12 months. 4. How will the facility monitor corrective action(s) to ensure deficient practice does not re-occur? The Administrator is responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x3 months to review audit results to determine trends and/or further follow up if needed.	

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F 730	Continued From page 15 a performance review every 12 months and the SDC was responsible for overseeing and making sure that the reviews were completed.	F 730		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight	F 842		4/18/25

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F 842	Continued From page 16 activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to maintain psychiatric progress notes in the electronic medical record (Residents #21, # 31, #37 and #90), and to accurately document the completion of an order on the medication administration record (Resident #36).	F 842	F842 Resident Records 1. What corrective action will be accomplished for each resident found to be affected by deficient practice? Residents #21, #31, #37, and #90	

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F 842	Continued From page 17 This deficient practice occurred for 5 of 5 residents (Resident #21, # 31, #36, #37 and #90) reviewed for accurate medical records. The findings included: 1a. Resident #21 was admitted to the facility on 10/9/24 with diagnoses that included dementia with other behavioral disturbances. A physician order for Resident #21 dated 10/24/24 ordered psychiatric services for evaluation and treatment. A quarterly Minimum Data Set (MDS) assessment dated 12/10/24 indicted Resident #21 had severe cognitive impairment and received antipsychotic, antianxiety and antidepressant medications. A review of Resident #21's electronic medical record (EMR) did not include any psychiatric progress notes. A request for psychiatric progress notes was made to the Administrator and hard copies of the visit notes were printed by the facility for 12/19/24, 1/2/25, 1/24/25, and 2/21/25. 1b. Resident #31 was admitted to the facility on 6/1/21 with diagnoses that included dementia, major depressive disorder and anxiety disorder. A physician order for Resident #31 dated 8/14/23 ordered psychiatric services consult. A psychiatric progress note dated 4/8/24 indicated Resident #31 was to have follow-up in four weeks.	F 842	psychiatric progress notes were uploaded into the electronic medical record (EMR) by 4/17/2025. Resident #36 catheter was removed as ordered by the physician and documented accurately in the medical record by charge nurse on 3/17/2025. 2. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice? All residents who are seen being seen by Psychiatric services are at risk for this deficient practice. The Medical Records Coordinator will review the current residents that receive psychiatric services to ensure psychiatric progress notes have been uploaded into the EMR by 4/17/2025. 3. What measures are put in place or systemic changes are made to ensure the practice will not re-occur? The process has been altered for psychiatric consult progress notes to be sent directly to the Medical Records Coordinator from the provider. The Director of Nursing educated the Medical Records Coordinator regarding ensuring psychiatry notes are uploaded into the EMR by 4/17/2025. Newly hired medical records coordinators will be required to complete this education during facility orientation prior to working. The Director of Nursing/ Staff Development Coordinator will educate the licensed nurses by 4/17/2025 related to ensuring orders are accurately documented in the medical record. Newly hired licensed nurses will be required to	

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F 842	Continued From page 18 A review of Resident #31's EMR did not include any psychiatric progress notes after 4/8/24. An annual MDS assessment dated 2/10/25 indicated Resident #31 had severe cognitive impairment and received antianxiety and antidepressant medications. A request for psychiatric progress notes was made to the Administrator and hard copies of the visit notes were printed by the facility for 7/18/24, 9/2/24, 10/3/24, 11/7/24, 12/5/24, 1/2/25, 1/30/25, 3/1/25 and 3/14/25. 1c. Resident #37 was admitted to the facility on 3/27/19 with diagnoses that included major depressive disorder, insomnia, anxiety disorder and dementia. A psychiatric progress note dated 4/26/24 indicated Resident #37 was to have follow-up in four weeks. A review of Resident #37's EMR did not include any psychiatric progress notes after 4/26/24. A quarterly MDS assessment dated 1/30/25 indicated Resident #37 had severe cognitive impairment and received antianxiety and antidepressant medications. A request for psychiatric progress notes was made to the Administrator and hard copies of the visit notes were printed by the facility for 7/5/24, 8/2/24, 9/2/24, 10/3/24, 10/31/24, 11/21/24, 12/19/24, 1/16/25, 2/21/25 and 3/13/25. 1d. Resident #90 was admitted to the facility	F 842	complete this education during facility orientation prior to working. 4. How will the facility monitor corrective action(s) to ensure deficient practice does not re-occur? The Director of Nursing/ Unit Managers will audit 5 resident charts that receive psychiatric services weekly for 4 weeks and monthly x 1 month to ensure psychiatric notes are being uploaded into the medical record as required. The Administrator is responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x 3 months to review audit results to determine trends and/or follow up if needed.	

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F 842	Continued From page 19	F 842		

10/2/24 with diagnoses including Alzheimer's disease and anxiety.

A physician order for Resident #90 dated 12/18/24 ordered a psychiatry evaluation.

The significant change MDS assessment dated 1/18/25 assessed Resident #90 to be severely cognitively impaired and he received antipsychotic medications.

A care area assessment dated 1/18/25 documented Resident #90 was receiving psychotropic medications, and he was seen by psychiatric services.

Review of Resident #90's EMR revealed no psychiatric progress notes.

A request for psychiatric visit notes was made to the Administrator and hard copies of the visit notes were printed dated 12/20/24, 1/23/25, 2/21/25, and 3/14/25.

The Social Worker was interviewed on 3/19/25 at 12:56 PM and stated that the psychiatric provider visited the facility weekly and provided progress notes by email to the Social Worker and Director of Nursing (DON). She stated the facility policy was for them to be printed off so the physician could review the progress notes before they were uploaded to the EMR. She was unable to explain why Residents #21, #31,#37 and #90 were missing psychiatric progress notes in their EMR. The Social Worker had been out of the facility from December 2024 to March 16, 2025.

An attempt to interview the previous Social Worker was made on 3/20/25 at 10:10 AM and

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F 842	Continued From page 20	F 842		

was unsuccessful. She had been employed at the facility from December 2024 to March 2025.

An interview occurred with the Medical Records Clerk on 3/20/25 at 10:51 AM. She explained there was a process for psychiatric progress notes where the physician reviewed them and then they would have been uploaded to Residents #21, #31, #37 and #90 EMRs. She was unable to explain why there were missing psychiatric progress notes in their EMR.

The DON was interviewed on 3/20/25 at 12:33 PM and could not explain why the psychiatric progress notes were not part of Residents #21, #31, #37 and #90's EMR as they should be.

On 3/20/25 at 11:49 AM, the Administrator was interviewed. He had begun employment at the facility in January 2025. The Administrator was unable to explain why the psychiatric progress notes for Residents #21, #31, #37 and #90 were not in their EMR as they should be.

2. Resident #36 was admitted to the facility on 3/17/23 with diagnoses that included history of stage 3-4 pressure ulcer.

Resident #36 had a physician order dated 03/11/25 that read; discontinue the indwelling urinary catheter on 03/15/25.

Resident #36's medication administration record (MAR) indicated the indwelling urinary catheter was removed on 3/15/25 by Nurse #6.

Further review of Resident #36's medical record revealed there were no orders to reinsert the

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F 842	Continued From page 21 indwelling urinary catheter. An observation conducted on 3/17/25 at 10:21 AM revealed Resident #36 was lying in bed resting and had an indwelling urinary catheter draining to a bedside drainage bag. A phone interview with Nurse #6 on 3/20/25 at 8:04 AM indicated she was the 3rd shift (11pm-7am) nursing supervisor on 3/14/25 to 03/15/25. She indicated she did not recall seeing an order to remove Resident #36's indwelling urinary catheter on 3/15/25 nor did she remove the catheter. Nurse #6 was unable to explain why it was documented on the MAR that she completed the order to remove Resident #36's indwelling urinary catheter. An interview was conducted with the Director of Nursing (DON) on 3/20/25 at 11:05 AM. The DON revealed she was not aware Resident #36's indwelling urinary catheter was not removed on 3/15/25 per the physician's order. The DON stated if Nurse #6 did not remove Resident #36's indwelling catheter on 3/15/25 then she should not have documented on the MAR that the order was completed.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/18/25

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	345562	A. BUILDING _____ B. WING _____	C 03/21/2025

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F 880	Continued From page 22 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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	345562	A. BUILDING _____ B. WING _____	C 03/21/2025

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

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F 880	Continued From page 23 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility staff failed to perform hand hygiene during meal service for 1 of 4 staff observed (Nursing Assistant #2) and failed to follow Enhanced Barrier Precautions (EBP) and apply personal protective equipment (PPE) prior to providing enteral feeding to a resident with a gastrostomy tube (G-tube) for 1 of 1 staff observed (Nurse #4) and failed to perform hand hygiene or apply new gloves during a dressing change to a G-tube for 1 of 1 observation for G-tube dressing changes (Nurse #1). The deficient practice occurred for 3 of 8 staff members reviewed for infection control practices. The findings included: The facility "Handwashing Policy" with a revision date of 4/2023 was reviewed and read, in part: "Personnel should wash their hands after contact	F 880	F880 Infection Prevention and Control 1. What corrective action will be accomplished for each resident found to be affected by deficient practice? NA #2 was educated regarding hand hygiene during mealtimes on 3/17/2025 by the Director of Nursing. Nurse #4 was educated regarding Enhanced barrier precautions on 3/18/2025 by the Director of Nursing. 2. What corrective action will be accomplished for those residents who have the potential to be affected by the deficient practice? All current residents have the potential to be affected by this deficient practice. The Director of Nursing/Designee will audit all residents who require Enhanced barrier precautions to ensure physician's	

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F 880	Continued From page 24 with body fluids, equipment or articles contaminated with body fluids; after removing gloves; before and after touching wounds; between resident contacts, when otherwise indicated to avoid transfer of microorganisms, and between tasks and procedures; an alcohol-based hand sanitizer may be used for handwashing unless the hands are visibly soiled." 1. The 300-400 hall dining room was observed on 3/17/25 at 12:31 PM. Nursing Assistant (NA) #2 was observed to be passing out meals to the residents. NA #2 was observed to cut food up for a resident, remove lids from drinks, and assist the resident to pick up the utensils. NA #2 was then observed to return to the counter and pick up another meal and deliver it to another resident without performing hand hygiene. NA #2 was observed to deliver multiple meals to residents in the dining room without performing hand hygiene between each delivery. NA #2 was observed again on 3/18/25 at 12:37 PM delivering meals to residents in room 301. NA #2 was observed to assist Bed A resident to sit up in bed, she adjusted the over-the-bed tray and assisted the resident to remove lids from her drinks. NA #2 returned to the dining room and did not perform hand hygiene before she picked up another tray to deliver to Bed B in room 301. NA #2 did not perform hand hygiene after assisting the resident with her tray, bed, and over-the-bed table. NA #2 was stopped as she headed to the meal service area to pick up another tray and asked about hand hygiene. NA #2 went to the wall mounted hand sanitizer and reported she was aware she should have used hand sanitizer	F 880	order, personal protective equipment (PPE) and required signage are in place by 4/17/2025. 3. What measures are put in place or systemic changes are made to ensure practice will not re-occur? The Staff Development Coordinator will complete education for all staff to include the licensed nurses, certified medication aides, certified nursing assistants, housekeeping/laundry staff, dietary staff, administrative staff, maintenance, social services clinical and therapy staff regarding Enhanced Barrier Precautions by 4/17/2025. The Staff Development Coordinator will complete education with the nursing staff to include the licensed nurses, certified nursing assistant, and certified medication aide regarding hand hygiene during mealtimes by 4/17/2025. The newly hired staff to include nursing staff, administrative staff, housekeeping/laundry staff, maintenance staff, dietary staff, therapy staff, and social service staff will be required to complete this education during orientation prior to working. 4. How will the facility monitor corrective action(s) to ensure deficient practice does not re-occur? The Director of Nursing/Designee will audit 5 residents requiring Enhanced	

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F 880	Continued From page 25 between the delivery of each meal, but she did not think about it during the meal service because she was trying to get the food to the residents as quickly as possible. The Director of Nursing (DON) was interviewed on 3/20/25 at 10:44 AM. The DON reported there was no supervision during the meal service to monitor if staff were performing hand hygiene. The DON reported NA #2 was very task oriented and was focused on getting meals to residents as quickly as possible and did not think to perform hand hygiene. 2. The facility "Enhanced Barrier Precautions" policy with a revision date of 6/13/2024 was reviewed, and read, in part: "EBP are used in conjunction with Standard Precautions to reduce the risk of MDRO transmission (multi-drug-resistant organisms, primarily bacteria that is resistant to one or more classes of antimicrobial agents [antibiotics] making infections caused by the bacteria difficult to treat) during high-contact resident care activities. Included with use of both gowns and gloves. EBP are meant to be in place for the duration of the resident's stay, or until ...discontinuation of an indwelling medical device occurs ...EBP apply to residents with any of the following: ... presence of indwelling medical devices with or without the presence of an MDRO infection or colonization ...Resident care activities that are considered high contact include, but are not limited to ...device care or use: ...feeding tube ... (Instructions included) perform hand hygiene with alcohol-based handrub or wash with soap and water before entering and after leaving the room; Wear gloves and a gown for the following high-contact resident care activities ...device care	F 880	barrier precautions 3x weekly x 1 month, then 5 residents weekly x 2 months to ensure ongoing compliance. The Director of Nursing/Designee will audit mealtimes 3x per week (to include breakfast, lunch, and dinner) x 3 months to ensure ongoing compliance with hand hygiene during meals. The Administrator is responsible for the plan of correction and monitoring of audits. The Quality Assurance Performance Improvement (QAPI) committee will meet monthly x 3 months to review audit results to determine trends and/or follow up if needed.	

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F 880	Continued From page 26 ...feeding tube ...take off and dispose gloves ...gown ...(and use) alcohol-based handrub or wash with soap and water ..." An observation of Resident #3's room was conducted on 3/18/25 at 12:30 PM. A sign with EBP instructions was posted on her door and a caddy with PPE was on the door, including gloves, gowns, and face masks. The EBP sign directed staff to perform hand hygiene, apply gloves and a gown when providing care to Resident #3. Nurse #4 was observed on 3/18/25 at 12:41 PM to enter Resident #3's room to provide G-tube feeding. Nurse #4 was observed to perform hand hygiene with hand sanitizer and apply gloves. Nurse #4 did not apply a gown. Nurse #4 went to Resident #3's beside and explained it was time for her G-tube feeding. Nurse #4 pulled the covers down and was removing the abdominal binder when she was stopped and asked to come to the door to read the EBP sign. Nurse #4 read the sign for EBP and reported she was going to complete the G-tube feeding without the gown because she was rushing to get the feeding completed. Nurse #4 removed her gloves, performed hand hygiene, and applied a gown to complete the G-tube feeding. Nurse #4 explained that she was aware of the EBP and PPE use, but she didn't think to apply it. The Director of Nursing was interviewed on 3/18/25 at 3:52 PM and she reported she was not aware Nurse #4 did not apply appropriate PPE to provide a G-tube feeding to Resident #3, and she expected all staff to read the signs on the doors and apply the appropriate PPE for resident care.	F 880		

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F 880	Continued From page 27	F 880		

3. According to the facility's infection control policy subsection titled Enhanced Barrier Precautions dated 4/03 and revised 6/13/24, personal protective equipment (PPE) including a gown and gloves was to be worn during high contact care for a resident with an indwelling medical device such as a feeding tube.

On 3/19/25 at 10:06 AM Nurse #1 donned a gown and gloves at the doorway of Resident #100's room due to the resident being on enhanced barrier precautions. Nurse #1 was observed as she provided a dressing change of the (PEG) percutaneous endoscopic gastrostomy tube (a thin, flexible tube inserted through the skin and into the stomach) insertion site. After cleansing the insertion site and applying a clean dressing, Nurse #1 removed her gloves and took a pen out of her pocket. Without performing hand hygiene or donning a clean pair of gloves, she then used her bare left hand and stabilized the newly applied dressing against the resident's stomach and wrote her initials and date on the tape of the dressing. Nurse #1 was interviewed immediately upon exiting the room. She stated that she knew the resident was on enhanced barrier precautions, but she did not want to touch her pen with the gloves she had been wearing. She stated that she should have had a pen readily available and changed gloves to write the date on the dressing instead of using her bare hand.

The Director of Nursing (DON) was interviewed on 3/19/25 at 10:42 AM, and she stated that Nurse #1 should have followed the instructions for the facility's policy on enhanced barrier precautions.

The Nurse Practitioner was interviewed on

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F 880	Continued From page 28 3/19/25 at 11:46 AM, and she stated that she expected the staff to follow written orders for a resident placed on enhanced barrier precautions when providing care to the residents. On 3/20/25 at 2:00 PM the Administrator was interviewed. He stated he expected the facility's staff to follow the infection control policy when providing care to all residents.	F 880		