STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G038	A. BUILDING _____ B. WING _____	C 04/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR CREEK	11950 HOWELL CENTER DRIVE CHARLOTTE, 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
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Complaint Intake #: NC00137861 Based on observation, review of facility records and interviews, the facility failed to provide each employee with training related to the needs of 1 of 1 client reviewed during the complaint investigation (client #1). The finding is: Observations conducted in the facility on 4/24/18 at 1:45 PM, during a complaint investigation, revealed client #1 was sitting in her wheelchair in the common room area of her unit with staff supervision. Client #1 was observed to be wearing bilateral foot booties. Review of the facility's investigation for client #1, dated 4/3/18, revealed this client had sustained an injury of unknown origin on or about 4/3/18 resulting in a fracture to the 2nd toe of her left foot. Included in the facility's investigation was a physical therapy consultation dated 4/10/18 documenting client #1 should wear bilateral protective footwear described as thickly padded booties or multi-podus boots with a hard back and hard foot plate. Further review of the 4/3/18 investigation revealed the facility concluded the investigation on 4/11/18 with recommendations for all staff involved in the care of client #1 to receive training related to the use of protective footwear for client #1. Review of an in-service	W 189		

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

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W 189	Continued From page 1	W 189		

training conducted by the unit qualified intellectual disabilities professional (QIDP) dated 4/6/18 revealed guidelines for the use of protective footwear (booties) for client #1 indicating: "Booties should be put on the client before transferring her to her wheelchair, to prevent injury to her feet. Booties are to be worn at all times during the day and in bed at night, and should only be removed during her shower". Additional review of the in-service training revealed no staff signatures verifying third shift staff had been provided with the training, and no signature from 3 of 4 staff identified by the facility's investigation as having provided care for client #1 during the 24 hours prior to client #1's injury being identified.

Interview with the unit QIDP on 4/24/18 revealed a new pair of booties for client #1, referenced in the 4/10/18 physical therapy evaluation, had been ordered, however they were not available for use at this time. Further interview with the QIDP verified current guidelines for the client's booties remain as indicated in the in-service to staff on 4/6/18. Interview with staff assigned to client #1 on 4/24/18 at 1:50 pm revealed the staff to report the client should wear booties at all times while in her wheelchair but not while in bed or in the shower. Interview with the QIDP verified the staff's understanding of the client's guidelines for wearing booties was incorrect and the client should wear her booties while in bed. Additional interview with two other unit staff also revealed incorrect understanding of the client's current guidelines relative to the prescribed booties. Subsequent interview with the unit QIDP revealed he was unsure why no staff on third shift had signed the in-service training of 4/6/18 relative to guidelines for client #1's booties. The QIDP

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W 189	Continued From page 2 indicated the training of third shift staff should have been provided by the lead staff of that shift. Therefore, the facility failed to provide training for all staff providing care for client #1 related to the use of protective footwear and failed to assure staff's accurate understanding of training provided.	W 189		