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 _____	08/11/2021

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 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 2 of 9 sampled clients (#2, #9) received a continuous active treatment program consisting of needed interventions as identified in the person-centered plan (PCP). The findings are: A. The facility failed to implement interventions for client #9 relative to ambulation support. For example: Observation in the Greenwood unit's dayroom on 8/10/21 at 4:30 PM revealed each client to be prompted and/or assisted with handwashing prior to the dinner meal. Continued observation revealed client #9 to be assisted by two staff, one on each side, to walk to the sink for handwashing. Further observation at 4:35 PM revealed client #9 to trip and fall forward while staff were assisting him back to his chair, landing on his hands and knees. Further observation revealed staff to assist client #9 back to his feet and to support the client back to his chair. Subsequent observation revealed staff to immediately contact the nurse who assessed client #9 for injuries and requested	W 249	W249: (#9) A: All Direct Support Staff will be trained on the proper way to utilize a gait belt with assistance from one staff for Client #9. Qualified professional will train All Direct Support Staff on the proper way to utilize a gait belt for Client #9. The team will monitor the progress with formal training by QP and the Habilitation Specialist for Client #9 when utilizing ambulation for short distances and during ambulation activities. The team will monitor the progress with interaction and meal assessment at a rate of 3 times per week for each assessment for one month period, then on routine basis thereafter. In the future, the team will ensure Person Centered Plans are implemented as prescribed. DHSR - Mental Health SEP 01 2021 Lic. & Cert. Section	

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

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.

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 _____	08/11/2021

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 249		W 249	
	Continued From page 1 that staff retrieve his gait belt. Additional observation at 4:43 PM revealed staff to enter the dayroom with client #9's gait belt and secure it to his waist. Review of client #9's record on 8/11/21 revealed a person-centered plan (PCP) dated 10/9/20. Continued review of the PCP indicated the client "utilizes a gait belt when ambulating for short distances." Further review of the client #9's record revealed a physical therapy (PT) evaluation dated 10/9/20. Continued review of the PT evaluation indicated "a gait belt is worn during ambulation activities with +1 assistance." Further review of the PT evaluation indicated a recommendation that client #9 has "assistance with +1 contact guard with a gait belt for ambulation, transfers, etc. Manual wheelchair is used for long distances." Review of client #9's level II incident report on 8/11/21 for the incident on 8/10/21 indicated "no apparent injury noted. Guardian has no concerns regarding the incident." Interview with the nurse on 8/10/21 confirmed client #9 should always wear his gait belt when assisted by staff with ambulation. B. The facility failed to implement training objectives for client #2 relative to mealtime guidelines. For example: Observations on the Rock and Roll unit on 8/11/21 from 8:20 AM to 8:30 AM revealed client #2 to participate in the breakfast meal. The breakfast meal was observed to consist of eggs, grits, toast, water and milk. Further observations revealed client #2 to slouch over her plate,		W249-B The Team has implemented formal training programs specific to needs in dining skills for Client #2. In addition, the Habilitation Specialist and QP will In service All Direct Support Staff on formal training programs for Client #2 during mealtime. All Direct Support Staff also will be in service on reading Client #2 meal card at every meal to insure use of correct utensils, cups, feeding procedures, and special instructions. Qualified professional will train All Direct Support Staff on the adaptive equipment for Client #2 during mealtime. The team will monitor the progress with the formal training programs by completing mealtime assessments at a rate of 3 time per week, for a period of one month, then on a routine basis thereafter. In the future, the team will include objective training to meet the client' needs in dining skills.

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 _____	08/11/2021

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 249		W 249		

Continued From page 2 consume her food at a fast pace and to have hand tremors during the breakfast meal. At no point during the observation period was client #2 provided a wrist weight, plate box or shirt protector during the breakfast meal. Subsequent observations did not reveal staff to prompt client #2 to slow her rate of eating.

Review of the records for client #2 on 8/11/21 revealed a PCP dated 9/25/20. Continued review of the record for client #2 revealed an occupational therapy (OT) assessment dated 4/9/21 which indicated that client #2 requires a wrist weight for the right hand while eating to control tremors and requires hand over hand assistance to drink from a regular cup. Further review revealed a plate box is to be placed under the regular high sided plate to decrease distance, promote body alignment and reduce spillage of food.

Review of the meal card guidelines for client #2 also revealed that protective clothing is needed to due to spillage. Continued review of the meal card guidelines indicated that client #2 displays severe tremors while eating, eats at a fast pace and slouches over her food during meals. Further review of the meal card guidelines also indicated that staff should provide up to three verbal cues to client #2 to slow the rate of eating.

Interview with the QIDP on 8/11/21 verified that client #2 refuses to wear her wrist weight at times. Further interview with the QIDP verified that staff have been trained to provide client #2 with a plate box, shirt protector and wrist weight during mealtimes. Continued interview with the QIDP confirmed that all of client #2's goals were current. The QIDP additionally confirmed that

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 _____	08/11/2021

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 249	Continued From page 3 staff should follow meal card guidelines for client #2 to minimize tremors and prevent choking risk.	W 249	
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 3 sampled client's (#7) on the Greenwood unit received a nourishing, well-balanced diet including modified and specially prescribed diet relative to food allergies. The finding is: Observation of client #7's dayroom during dinner time on 8/10/21 at 5:23 PM revealed the client to participate in a family-style dinner meal that included beef, mashed potatoes, carrots, and choice of water, milk, chocolate milk, and crystal light. Further observation revealed staff to offer client #7 a choice between milk and chocolate milk, to which the client chose and consumed chocolate milk. Review of client #7's record on 8/11/21 revealed a person-centered plan (PCP) dated 3/27/21. Continued review of the PCP indicated a food allergy of "nuts, peanuts, shellfish, chocolate." Continued review of client #7's record revealed a nutritional evaluation dated 3/18/21. Review of the nutritional evaluation revealed client #7's food allergies include "tree nuts, peanuts, shellfish, chocolate."	W 460	W460/W488 The Team has implemented formal training programs specific to needs in food/ Nutrition and Dining skills for Client #7. In addition, the Habilitation Specialist and QP will In service All Direct Support Staff on formal training programs for Client #7 during mealtime. All Direct Support Staff also will be in service on reading Client #7 meal card at every meal to insure use of correct utensils, cups, feeding procedures, and any special instructions. The team will monitor the progress with the formal training programs by completing mealtime assessments at a rate of 3 time per week, for a period of one month, then on a routine basis thereafter. In the future, the team will include objective training to meet the client' needs in dining skills.

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 _____	08/11/2021

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 460		W 460		
	Continued From page 4 Interview with the qualified intellectual disabilities professional (QIDP) and facility nurse on 8/11/21 revealed that "chocolate is chocolate" and verified client #7 should not be offered chocolate milk based on the documented food allergies.			
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 of 3 sampled client's (#7) on the Greenwood unit ate in a manner consistent with his developmental level. The finding is: Observation of client #7 during the dinner meal on 8/10/21 and the breakfast meal on 8/11/21 revealed a 1:1 staff to sit next to the client and to feed him for the duration of each meal. Review of client #7's record on 8/11/21 revealed an occupational therapy (OT) evaluation dated 3/16/21. Review of the OT evaluation indicated client #7's adaptive equipment and meal card guidelines to include "feeds himself using a built-up spoon from home with his left hand regular." Continued review of the OT evaluation revealed strengths to include the client tolerates diet and feeds self with a built-up handled spoon from home or regular spoon, divided high-sided dish, protective clothing device and non-skid mat. Subsequent review revealed identified needs of maintaining functional independence with feeding	W 488		

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 _____	08/11/2021

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 488	Continued From page 5 and drinking. Further review of client #7's record revealed an adaptive behavior inventory (ABI) dated 3/20/20. Continued review of the ABI revealed the client has total independence and self-initiation with the ability to drink from a cup or glass, eats with a spoon with minimal spillage and eats with fork with minimal spillage. Interview with the qualified intellectual disabilities professional (QIDP) on 8/11/21 revealed she did not know of any reason for client #7 to be fed by staff, and verified the client should be allowed the opportunity to eat independently at every meal.	W 488		