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 _____	09/28/2022

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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: The facility failed to ensure the privacy of 4 of 7 audit clients on the Blue hall (#3, #5, #6 and #7) during care of personal needs as evidenced by observations, record review and interviews. The findings are: A. During observations on the blue hall on 9/28/22 at 7:16am, Blue Staff A was observed giving client #5 a shower. The bathroom door was open approximately six inches and the privacy curtain on the shower stall was open. Client #5 could be observed standing in the shower getting bathed and getting dressed. At no point during the observation did Blue Staff A close the privacy curtain or bathroom door. Review on 9/28/22 of client #5's adaptive behavior inventory (ABI) dated 1/16/19 revealed client #5 has no independence to close the bathroom door for privacy and requires full staff assistance to maintain her privacy. Interview on 9/28/22 with the qualified intellectual disabilities professional (QIDP) and program manager (PM) confirmed staff should ensure the privacy curtain on the shower stall and the bathroom door is closed to ensure client #5 is provided privacy during personal care. B. During observations on the blue hall on 9/28/22 at 7:07am, client #1 was observed to attempt to walk out of her bedroom several times, with staff telling her to sit back down in her	W 130	W130 (#5) A. All Direct Support Staff will be trained on the Client Rights for Client #5. Qualified Professional will train All Direct Support Staff on maintaining Client #5 privacy. The team will monitor the progress with formal training by QP and Habilitation specialist for Client #5 to maintain her privacy during her hygiene time. The team will monitor the progress with interaction assessment at a rate of 3 times per week for one month period. In the future, the team will ensure Person Centered Plan and ABI are implemented as prescribed. B. All Direct Support Staff will be trained on Client Rights for Client #1. Qualified Professional will train All Direct Support Staff on maintaining Client # 1 privacy along with Client # 3, #6 and #7 during their personal care time. All Direct Support Staff will also be train on keeping Client #1 in her room to avoid others privacy. The team will monitor the progress with formal training by QP and Habilitation specialist for Client #1 to maintain her privacy and others during personal care time. The team will monitor the progress with interaction assessment at a rate of 3 times per week for one month period. In the future, the team will ensure Person Centered Plan and ABI are implemented as prescribed.	11/1/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 10/17/22

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.

DHSR, Mental Health
OCT 27 2022
Lic. & Cert. Section

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W 130	Continued From page 1 bedroom. Blue Staff C was observed to take client #1 by the hand and lead her into the bedroom located next door that belongs to clients #3, #6 and #7. Blue Staff C directed client #1 to sit in a chair in the bedroom. During this time, clients #3, #6 and #7 received their personal care. Interview on 9/28/22 with the QIDP and PM confirmed client #1 should not be seated in the bedroom with her peers while they are receiving personal care to provide them with their privacy.	W 130		11/1/22
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure clients residing on the Blue hall had the right to retain personal possessions. The finding is: During observations on the Blue hall on 9/27/22, a shelf located outside of the day room was observed to hold containers of perfumes, lotions, deodorant, hair brushes and combs. None of the items located in the containers were labeled with a client's name. During additional observations on the Blue hall on 9/28/22 from 6:53am to 7:16am, several staff were observed to grab items from the containers on the shelf and walk into bedrooms and bathrooms. Further observations revealed staff to exit the bedrooms and bathrooms and place	W 137	W137 The team has implemented formal training to All Direct Support Staff for the individuals personal care items. Qualified Professional will in service All Direct Support Staff on all individuals having their own personal care items in a clear small bin and label. The team will monitor the progress by completing interaction 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 ensure Person Centered Plans are implemented as prescribed	

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W 137	Continued From page 2 the items back into the containers on the shelf. Interview on 9/28/22 with Blue Staff B revealed the items on the shelf are community items that the clients share. Blue Staff B revealed she tries to use the same item for the same client each time, but confirms the items are not labeled and therefore, it is unlikely this happens. Interview on 9/28/22 with the qualified intellectual disabilities professional (QIDP) and program manager (PM) confirmed clients should not be sharing personal care items and should have their own.	W 137		11/1/22
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation and interview, nursing services failed to ensure that staff were adequately trained to ensure privacy during medication administration for 3 clients (#9, #13, #16) on the yellow unit. The findings are: Observations in the facility on 9/27/22 from 3:45 PM-7:00 PM revealed clients to participate in various activities in the day room. Continued observations at 5:15 PM revealed staff C to administer client #13 medications in a cup in the day room while other peers and staff were in the room. Observations also revealed staff C to name the medications that client #13 received.	W 340	W 340 Nursing services and nursing leadership recognize the importance of ensuring privacy when medical care is being provided. Our staff (which consists of medication technicians, CNAs, LPNs and RNs) are all trained at the time they are hired on the correct way to administer medications. We also go a step further by providing ongoing in-services and trainings on medication administration dos and don'ts on a quarterly basis. As a plan of corrections to address the issues witnessed by medication technician C during the survey, nursing leadership will increase our trainings from quarterly to monthly for 3 months. Clear Creeks Director of Nursing	

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W 340	Continued From page 3 Observations did not reveal staff to ensure the privacy of client #13 by taking him outside of the day room to administer medications. Observations on 9/27/22 at 6:00 PM revealed staff C to administer medications to client #9 in the day room with other peers in the room. At no point during the observation did staff ensure the privacy of client #9 during medication administration by either removing her from the room or using one of the two privacy screens in the day room. Observations on 9/27/22 at 6:15 PM revealed staff C to administer afternoon medications to client #16 in the day room with other peers and staff present in the room. Observations did not reveal staff to ensure the privacy of client #16 by either using one of the two privacy screens or removing the client from the day room to administer medications. Interview with the qualified intellectual disabilities professional (QIDP) on 9/28/22 revealed staff have been trained to either remove the clients from the day room, take them into their rooms with the door closed or use a privacy screen in the day room when administering medications. Interview with the facility nurse on 9/28/22 revealed all clients should be offered privacy during medication administration.	W 340	The trainings will include the importance of not administering medication to the people we support in a common area. Instead, medications must be given in the nurses' station or an individual's private bedroom with the door closed. If the individual is unable to be moved to another area, a privacy screen must be used as a last resort Director of Nursing will re-trained on the importance of telling the people we support the names of the medications and what they are used for however this must be done in a private area. Do tell the individual what he or she is taking and why, DO NOT provide this information in an area where others can hear. To ensure privacy is maintained, Nursing leadership will increase the number of med pass audits from 1 per unit per month to 4 per unit per month for 3 months. Nursing services will also provide a training to the other members of the interdisciplinary team on the importance of maintaining privacy during medication administration and when providing all care.	11/1/22
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by:	W 382		

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W 382	Continued From page 4 The facility failed to assure all medications were secured appropriately as required as evidenced by observations and interviews. The finding is: During observations on the Blue hall on 9/28/22 at 7:46am, the nurse was observed to walk away from the medication cart, into a client's bedroom and close the door. The medication cart was located in the hallway with the cart unlocked and the top two drawers slightly open. Interview on 9/28/22 with the nurse revealed she should have locked the medication cart prior to walking away and into the client's bedroom and confirmed she should not leave the medication cart unattended and unlocked. Interview on 9/28/22 with the director of nursing (DON) confirmed the medication cart should not be left unlocked and unattended.	W 382	W 382 All nursing staff have been re-trained by the Director of Nursing on the importance of ensuring the medication cart is locked at all times when it is unattended. Ensuring the medication cart is locked at all times when not in use has been added to the monthly in-services/trainings for all nursing staff. We will repeat this information monthly for the next three months.	
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: A. Based on observation, record review and interview, the facility failed to furnish and maintain in good repair the use of adaptive equipment for clients (#8, #10, #11, #14, #15, #16) on the yellow unit. The findings are: A. The facility failed to ensure that wheelchairs were in good condition for clients #8, #11, #15	W 436		

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W 436	Continued From page 5 and #16 on the yellow unit. For example: Observations during the 9/27/22 - 9/28/22 survey revealed clients to participate in various activities on the unit. Continued observations on 9/27/22 at 1:30 PM revealed client #15 to sit in the day room in his wheelchair. Further observations revealed client #15's wheelchair headrest to be torn approximately 6" in diameter. Observations on 9/27/22 at 1:45 PM revealed client #16 to sit in the dayroom in her wheelchair. Continued observations revealed the wheelchair to have a white towel and white duct tape wrapped around the left arm rest. Further observation revealed client #16's wheelchair to also have a torn area on the right arm rest. Observations on 9/27/22 at 1:55 PM revealed client #8 to participate in an activity in the dayroom in her wheelchair. Continued observation revealed client #8's left arm rest torn and cracked in two places. Subsequent observations on 9/27/22 at 3:55 PM revealed client #11 to sit in her wheelchair in the day room. Continued observations revealed the wheelchair headrest of client #11's to be torn and peeling. Interview with the qualified intellectual disabilities professional (QIDP) on 9/28/22 revealed the facility completed wheelchair maintenance checklists the previous week and all repairs were reported on a work order request form. Interview with the facility administrator revealed the wheelchair maintenance checklists and work orders for clients #8, #11, #15 and #16 could not be located during the survey. Continued	W 436	W436 A. All Direct Support Staff will be train on completing work orders for wheelchair repairs for Client #8, #11, #15 and #16. Qualified Professional will in service All Direct Support Staff on the proper way to complete and turn in a wheelchair work order. The team will monitor the progress with keeping a log when work orders being reported and completed.	

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W 436	Continued From page 6 interview with the facility administrator verified all clients should have adaptive equipment in good repair and good working condition. B. The facility failed to ensure bedroom furniture was in good condition for clients #10 and #14 on the yellow unit. For example: Observations on 9/28/22 at 6:45 AM revealed client #10 to have padding on the headboard and footboard of her bed. Continued observation revealed the footboard to have the padding torn, missing and protruding approximately 15" in diameter. Further observation revealed the headboard to have a large vertical tear in the padding approximately 20" in diameter. Subsequent observation at 7:00 AM revealed client #14 to have the footboard padding peeling approximately 13" in diameter. Interview with the QIDP on 9/28/22 revealed client #10 must have the headboard and footboard covered with padding to ensure safety due to the client's self-injurious behaviors (SIBs). Continued interview with the QIDP revealed client #10 will often pull out the padding in her footboard and ingest it. Continued interview with the QIDP revealed the facility will often replace client #10's padding when she tears and pulls out the padding. Subsequent interview with the QIDP on 9/28/22 revealed client #14 must also have his headboard and footboard padded due to behaviors. Continued interview with the QIDP revealed staff should have reported the headboard and footboard padding was tampered and damaged for both clients #10 and #14. Further interview	W 436	W.436 B. The team had a meeting and discuss discontinuing of removing the pad from the headboard and foot board for Client #10 and #14. Qualified Professional completed addendum to Client # 10 and #14 Person Centered Plan to address discontinuing the padding.	11/1/22

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W 436	Continued From page 7 revealed all clients should have bedroom furniture in good condition.	W 436		11/1/22
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: The facility failed to assure fire drills were conducted quarterly for each shift of personnel as evidenced by interview and record verification. The finding is: Review of the facility's fire drill evacuation reports, substantiated by interview with the facility administrator, revealed the facility runs with 3 shifts of staff covering 4 separate resident units. Further review of the fire evacuation reports and interview with the facility administrator revealed reports for each month usually included only one drill for one resident unit each month. For example, of the 18 reports over the past year, 9 reports were from Green Unit, 4 reports were from Blue Unit, 4 reports were from Orange Unit and 1 report was from B-side. No reports were noted for the Yellow Unit for the past year. In addition, 10 of the reports over the past year were noted to be on 3rd shift, 3 were noted on 2nd shift and 5 reports were on 1st shift. The facility failed to assure fire drills were conducted at least quarterly for each area for each shift of personnel as required.	W 440	W440/W448 The facility has increase the number of drills per units, 1 per unit per month. All shifts will be included. The facility will maintain a log to track the number of fire drills per unit, per month. And times it takes to complete each drill. Evacuations will be included if part of the response at finish of each drill. The Unit Administrator will keep a track of this Monthly.	
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: The facility failed to assure they were able to	W 448		

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W 448	Continued From page 8 thoroughly investigate any problems with fire evacuations by failing to document their fire evacuation reports adequately as evidenced by interview and record verification. The finding is: Review of the facility's fire evacuation reports over the past year, substantiated by interview with the facility administrator, revealed only 18 drills were conducted over the past year. Further review of those reports and interview with the facility administrator revealed none of the reports included the amount of time each drill took to complete to be able to evaluate the effectiveness of the staff and drill. Continued review of the fire evacuation reports revealed 8 of the 18 reports also had data missing relative to the time that the drill was conducted, the number of clients who were on the unit or the number of staff who participated in the drill to better evaluate any problems with the fire drills.	W 448		