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 _____	09/17/2024

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 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 3 clients (#10, #11 and #12) were provided the opportunity for privacy. The findings are: A. The facility failed to ensure client #10 on the Green Unit was provided privacy during medication administration, breakfast and participating in leisure activities in the day room. For example: Afternoon observations on 9/16/24 between 4:00PM - 6:15PM revealed client #10 to sit in his wheelchair in his bedroom with no shirt on. Continued observations at 4:45 PM revealed the medication technician (med tech) to propel client #10 from his room to the medication room with no shirt on. Further observations revealed the med tech to return client #10 back to his room with no shirt on. At no point during observation was client #10 prompt or offered to put on a shirt. Interview with a staff in client #10's bedroom revealed client #10 does not like to wear shirts. Continued interview with staff revealed client #10 will take his shirt off and not want to put it back on. Further interview revealed client #10 will at times remain shirtless all day. Morning Observations on 9/17/24 between 6:00AM - 8:05AM revealed client #10 to lay on a mat with a pull up and shirtless in his room asleep while the door remained opened. Continued	W 129		

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

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 _____	09/17/2024

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 129	Continued From page 1	W 129		

observations at 8:15AM revealed client #10 in the day room with a shirt on. Further observations at 8:20AM - 9:10AM revealed client #10 shirtless while being tube fed and listening to staff read a book to the group, and prompt to engage in leisure activities.

Interview with staff in the day room at 9:05AM revealed client #10 doesn't like to wear shirts and removed his shirt that he had on earlier. When asked how do you provide privacy for the client while sitting amongst his peers and/or being tube fed? Staff responded "I'll get a blanket to cover him or put his shirt back on".

Interview on 9/17/24 with the program administrator (PA), and program manager (PM) verified that client #10 doesn't like to wear shirts. Continued interview with the PA and PM confirmed the client should be wearing a shirt, outside of his bedroom, especially when transferring out of his bedroom.

B. The facility failed to ensure client #11 on the Green Wing was provided privacy during a phone call with a family member. For example:

Observations on 9/17/24 at 7:30AM revealed client #11 to sit on a chair in the hallway on the phone conversing with a family member. Continued observations revealed the conversation between the client and his mother to be heard throughout the hallway. Further observations revealed client #11's one-on-one (1:1) staff and another staff sitting in a chair in the hallway, numerous staff walking up and down the hallway while client #11 was on the phone. At no point during observations was the client prompted or offered to transfer their call to another area so

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 _____	09/17/2024

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 129	Continued From page 2	W 129		

that the conversation could not be overheard.

Interview on 9/17/24 with client's #11's 1:1 staff revealed that the client prefers to talk on the phone using the speaker because he dislikes holding the phone with his hand. Continued interview with 1:1 staff revealed the client also prefers to use the phone in the hallway and does have options in where he can use the phone.

Interview on 9/17/24 with the PA confirmed a phone is accessible in the facility where all clients can hold private telephone conversations. The PA also confirmed client #11 should have been offered the opportunity to transfer to another room with a telephone where he could have privacy and his conversations could not be overheard.

C. The facility failed to ensure client #12 on the Orange Wing was provided privacy while waiting on staff to get dressed after a shower. For example:

Observations on 9/17/24 at 7:12AM revealed client #12 to wonder out of his bedroom naked and down the hallway toward staff voices. Continued observations revealed staff to tell client #12 to go back to his bedroom. Further observations revealed client #12 to continue walking down the hallway. Subsequent observations revealed a staff down the hallway to take client #12 to the bathroom to place an attends on him. Additional observations revealed the staff to escort client #12 from the bathroom to his room where they assisted him to get dressed.

Interview on 9/17/24 with PD revealed client #12 can be left alone in his room. Continued interview

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 _____	09/17/2024

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 129	Continued From page 3 with PD revealed client #12 can ambulate alone but should have on non-skin socks. Further interview with the PD revealed staff providing supervision at the door of another client could have left the doorway to provide immediate attention to client #12. Subsequent interview with the PD revealed client #12 should have been dressed.	W 129		
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 reviews and interviews, the facility failed to ensure clients received a continuous active treatment program consisting of needed interventions and services as identified in the Person-Centered Plan (PCP) for 5 clients (#4, #7, #15, #16 and #17) relative to implementing training objectives and providing adaptive equipment. The findings are: A. The facility failed to ensure informal opportunities were utilized for appropriate skill development during mealtimes for client #4 on the blue unit. For example: Observations during the evening mealtime on	W 249		

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 _____	09/17/2024

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 4	W 249		

9/16/24 at 5:09PM revealed client #4 to participate in dinner in the day room at the dining table. Continued observations revealed client #4 was served shredded chicken, sliced peaches, and mashed blueberries in a divided dish; staff provided client #4 with a regular spoon. Further observation revealed client #4 ate her food using only her hands until completion. At no point did staff prompt client #4 to use her spoon or provided hand-over- hand to assist client #4 in developing a skill to utilize her spoon during the mealtime.

Observations during the morning mealtime on 9/17/24 at 8:12AM revealed client #4 to participate in breakfast in the day room at the dining table. Continued observation revealed client #4 was served a pancake with syrup and mashed blueberries in a divided dish; staff provided client #4 with a regular spoon. Further observation revealed client #4 ate her food using only her hands until completion. At no point did staff prompt client #4 to use her spoon or provided hand- over- hand to assist client #4 in developing a skill to utilize her spoon during the mealtime.

Interview with the program manager (PM) on 9/17/24 revealed staff should have prompted client #4 to use her spoon or provided hand-over-hand assistance.

B. The facility failed to ensure that clients were provided adaptive equipment during transition and ambulation for client #15 on the yellow unit. For example:

Observations during the recertification survey from 9/16/24-9/17/24 revealed client #15 to

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 _____	09/17/2024

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 5	W 249		

participate in various activities to include transitioning to bathroom for personal care, to the medication room, to the day room for mealtimes and activities, and transitioning to her room without a gait belt. At no point during the observation period did staff offer client #15 a gait belt to assist with ambulation to various activities.

Review of the record for client #15 on 9/17/24 revealed a PCP dated 2/27/24 which indicated that the client must wear a gait belt. Continued review of the record did not reveal an updated PT assessment for client #15 during the survey.

Interview with the qualified intellectual disabilities professional (QIDP) and PM on 9/17/24 revealed that client #15 still has a gait belt and it must be used when the client is transitioning around the facility. Continued interview with the PM verified that all of client #15's interventions and program goals are current. Further interview with the PM verified that staff have been trained to utilize client #15's gait belt during ambulation throughout the facility.

C. The facility failed to ensure that client #17 had immediate access to her gait belt during ambulation on the yellow unit. For example:

Observations during the recertification survey from 9/16/24-9/17/24 revealed client #17 to ambulate throughout the facility in a wheelchair. Continued observations revealed client #17 to participate in various activities to include transitioning to bathroom, medication room, to the day room for mealtimes and activities, and transitioning to her room without a gait belt. At no point during the observation period did staff offer or keep a gait belt within close proximity to assist

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 _____	09/17/2024

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 6 client #17 with ambulation to various activities. Review of the record for client #17 on 9/17/24 revealed a PCP dated 11/2/23. Continued review of the record for client #17 revealed a PT assessment dated 1/30/24 which indicated that client #17 must have access to her gait belt with contact guard assist. Interview with client #17 on 9/17/24 revealed that her gait belt is kept in her room unless she is using her walker. Interview with the QIDP on 9/17/24 revealed that client #17 keeps her gait belt in her room unless she is walking around the facility. Interview with the program administrator on 9/17/24 revealed that client #17 should have her gait belt within arms reach or on her wheelchair during ambulation to assist with transition. Continued interview with the PM verified that all of client #17's interventions and program goals are current. Further interview with the PM verified that staff have been trained to keep client #17's gait belt either on her wheelchair or within arm's reach. D. The facility failed to ensure that adaptive equipment was properly used for client #16 during ambulation on the yellow unit. For example: Observations throughout the recertification survey from 9/16/24-9/17/24 revealed staff to walk with client #16 with contact guard assistance to transition her to various activities to include the day room, bathroom, medication room, and to her bedroom. Continued observations revealed staff to either hold client #16's hand or allow the client the ambulate in front of them and not using her gait belt during ambulation.	W 249		

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 _____	09/17/2024

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 7	W 249		

Review of the record for client #16 on 9/17/24 revealed a PCP dated 5/16/24 and PT Assessment dated 8/2/24 which indicated that client wears a gait belt for ambulation due to seizure activity and osteopenia diagnoses. Continued review of the 8/2/24 PT assessment revealed that staff should continue to use the gait belt with contact guard assistance to ensure client #16's safety and well-being. Further review of the 8/2024 PT assessment indicated that client #16's gait belt should be worn daily during waking hours with one person contact guard assistance for transfers, standing, sit to stand, and ambulation.

Interview with the QIDP and PM on 9/17/24 revealed that staff should use the gait belt with contact guard assistance while client #16 is ambulating throughout the facility. Interview with the PM verified that all of client #16's interventions and program goals are current. Continued interview with the PM verified that staff have been trained to hold the gait belt while client #16 is ambulating throughout the facility.

E. The facility failed to follow the positioning schedule on the green unit for client #7 as prescribed. For example:

Afternoon observations on 9/16/24 from 4:00PM - 6:15PM revealed client #7 to lay in bed. Continued observations in the day room revealed a Green Wing Positioning Schedule posted on the wall. Further review of the positioning schedule revealed 14 clients listed and schedule to begin at 7:00AM - 7:00PM to include client #9. Subsequent observations revealed no clients sitting in the day room. Additional review of the positioning schedule revealed the following for

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 _____	09/17/2024

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 8 client #7 during the following times; 3:30PM - 4:30PM tilt/wheelchair, 4:30PM-5:30PM wheelchair, 5:30PM-6:30PM wheelchair, and 6:30PM- 7:00PM bed. At no point during observation was client #9 participating in the positioning schedule as prescribed. Interview with the PM on 9/17/24 revealed the positioning schedule is current and should be followed daily as written.	W 249		
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 observations, record reviews and interviews, the system for drug administration failed to assure 3 clients (#9, #13, and #14) were provided the opportunity to participate in medication self-administration or provided teaching relative to name, purpose, and side effects of medications administered. The findings are: A. The system of drug administration failed to assure client #9 on the Green Unit was provided teaching relative to name, purpose and side effects of medication administered. For example: Observations on 9/17/24 at 9:00AM revealed client #9 to sit in the medication room to prepare for medication administration. Continued observations revealed the medication technician	W 340		

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 _____	09/17/2024

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 340	Continued From page 9	W 340		

(med tech) to place the following medications Calcium D3, L-Carnitine, Carvedilol, Eliquis, Oxcarbazepine, Furosemide, Senna Plus,Vitamin C, CO QID, Omeprazole, Vitamin D3, and Mucus Relief into a medication cup. Further observations revealed the med tech to pour boost powder into a plastic cup and mix with water. Subsequent observations revealed the med tech to open all capsules and pour the sprinkles into a pudding cup. Additional observations revealed the med tech to crush all tablets then pour into the pudding cup.

Observations at 9:05AM revealed the med tech to feed client #9 from the pudding cup, then stated" you've got all types of meds in here, something for constipation, coughing, chest congestion, we sure do" as client consumes his medications.

Interview with the Director of Nursing (DON) on 9/17/24 verified client #9 should participate in medication administration at some capacity. Continued interview with the DON revealed that staff should educate clients on the name, purpose and side effects of their medications.

B. The system of drug administration failed to assure client #13 on the Orange Unit was provided teaching relative to name, purpose and side effects of medication administered. For example:

Observations on 9/16/24 at 5:28PM revealed client #13 to be transported to the medication room by wheelchair for medication administration. Continued observations revealed med tech to place the following medications: 1 tab-Lamatrogile 25 MG, 1 tab-Lamatrogile 100 MG, and 1 tab -Vitamin C 500 ML into a medication

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 _____	09/17/2024

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 340	Continued From page 10 cup. Further observations revealed the med tech to place the three tablets into a pill crusher, crush and then mix part of contents with Nutren supplement and the other part with applesauce in a plastic cup. Subsequent observations revealed the med tech to ask client #13 if she would like to hold the cup to drink first dose or be fed some of the medications. Client #13 indicated she wanted to drink first. Additional observations revealed the med tech to feed client #13 the remaining crushed meds in applesauce. Interview with the DON on 9/17/24 verified client #13 should participate in medication administration at some capacity and staff should provide education of the medications clients are receiving. C. The system for drug administration failed to assure Client #14 on the Orange Unit was provided teaching relative to name, purpose and side effects of medication administration. For example: Observations on 09/17/24 at 7:30AM revealed the med tech go to client #14's bedroom door and invite him to the medication room for his medication pass. Continued observations revealed client #14 to walk into the medication room and handed his medications in a med cup. Further observations revealed client #14 to be handed a cup of water and told to take and his medications. Subsequent observations revealed client #14 to take his medications and attempt to leave the medication room until surveyor interrupted to ask what medications he had been administered. Additional observation revealed the med tech had prepared client #14's 1 tab -Clonazepam 0.5, 1 tab -Allegra, Peg Powder	W 340		

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 _____	09/17/2024

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 340	Continued From page 11 17G, 1/2 tab (12.5) Tetrabenazin 25 MG and 2 tab-Vitamin D3 2000 IU before he entered the medication room. Interview with the DON on 9/17/24 verified client #14 should participate in medication administration at some capacity. Continued interview with the DON revealed that staff have been trained to provide education to all clients while administering medications.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 2 clients on the blue unit (#19 and #20). The findings are: A. The facility failed to ensure all medications were administered to client #19 as prescribed per physician's order. For example: During observations of medication administration on 9/17/24 at 7:18AM, the medication technician (Med Tech) was observed to prepare client #19's 8:00AM medication by pouring the liquid medications into small cups, crushed all tabs and poured into a cup of water. Continued observations revealed the med tech to administer Lacosamide SOL 10mg/ml, Levetiraceta SOL 100mg/ml, Multivitamin, Omeprazole 20mg, Senna-plus 8.6-50mg, Sprintec 28, and Vitamin D3 50mcg via client #19's G-tube while she laid in	W 369		

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 _____	09/17/2024

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 369	Continued From page 12	W 369		

her bed. Further observations revealed the Med Tech then administered Nutren 1.5 liquid fiber via G-tube but did not flush with 60ml of water after feed. No other medications were administered at this time and the Med Tech returned to the med cart to prepare the next clients' medications.

Review on 9/17/24 of client #19's physician's orders dated 5/26/24 revealed an order for Calcitoni Salmon-200U, Peg3350 powder-510G, Greer's Goo Ointment, and Petrolatum Ointment 42% scheduled for 8:00AM daily.

Interview on 9/17/24 with the Med Tech revealed she thought client #19's medications were all inside the med cart and was unaware prior to administration that she was missing some medications. The Med Tech did notify the unit Nurse of the missing medications for client #19.

Interview on 9/17/24 with the Director of Nursing Services (DON) acknowledged the omission of client #19's medications and that the physician's order were current. Continued interview with the DON revealed the unit Nurse reordered client #19's missing medications today.

B. The facility failed to ensure all medications were administered to client #20 as prescribed per physician's order. For example:

During observations of medication administration on 9/17/24 at 7:47AM, the med tech was observed to prepare client #20's 8:00AM medication by crushing 5 tabs and poured into a cup of water; then opened 1 capsule and poured powder into the cup of water. Continued observations revealed the med tech to administer Baclofen 20mg, Bromocriptin cap 5mg,

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 _____	09/17/2024

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 369	Continued From page 13 Famotidine 20mg, Lamotrigine 200mg, and Oyster Shell 500mg via client #20's G-tube while she set upright in her wheelchair. Further observation revealed the med tech did not flush G-tube with 30ml of water after administering the medications. Subsequent observations revealed the med tech then administered Nutren 1.5 liquid fiber and water via G-tube. No other medications were administered at this time and the med tech returned to the med cart to prepare the next clients' medications. Review on 9/17/24 of client #20's physician's orders dated 9/6/24 revealed an order for Lactulose-10gm/15ml, Levetiraceta SOL 100mg/ml, and Senna Syrup 8.8/5ml scheduled for 8:00am daily. Continued review revealed an order to flush G-tube with 30ml water after medications. Interview on 9/17/24 with the Med Tech revealed she thought client #20's medications were all inside the med cart and was unaware prior to administration that she was missing some medications. The Med Tech did notify the unit Nurse of the missing medications for client #20. Interview on 9/17/24 with the DON acknowledged the omission of client #20's medications and that the physician's order were current. Continued interview with the DON revealed the unit Nurse reordered client #20's missing medications today.	W 369		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair,	W 436		

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 _____	09/17/2024

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W 436	Continued From page 14	W 436		

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:
Based on observations, record review and interview, the facility failed to assure that adaptive equipment was furnished as prescribed for 4 clients (#3, #6, #15, #16). The findings are:

A. The facility failed to assure adaptive equipment was furnished as prescribed for client #3 on the blue unit. For example:

Afternoon observations on 9/16/24 at 5:09PM revealed client #3 to sit at the dining room table to participate in the dinner meal. Continued observations revealed client #3 to use a regular spoon to eat his food and two regular cups for his drinks. Further observations revealed client #3 to cough (2X) after drinking and staff prompted him to slow down and paused between sips. At no point did staff provide client #3 with his prescribed small left handed curved spoon and a straw for his drinks.

Morning observations on 9/17/24 at 8:12AM revealed client #3 to sit at the dining room table to participate in the breakfast meal. Continued observations revealed client #3 to use a regular spoon to eat his food and two regular cups for his drinks. Further observations revealed client #3 to cough (1X) after drinking and staff prompted him to slow down and take his time. At no point did staff provide client #3 with his prescribed small left handed curved spoon and a straw for his drinks.

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W 436	Continued From page 15	W 436		

Review of the record for client #3 revealed a Nutrition Assessment dated 9/29/23 which revealed the client uses a small left handed curved spoon and a straw with staff assisting at times by holding the regular cup.

Interview with the program administrator (PA) on 9/17/24 revealed that client #3's nutrition assessment was current and he should have been provided his small left handed curved spoon and a straw during mealtimes.

B. The facility failed to assure adaptive equipment was furnished as prescribed for clients #6, #15 and #16 on the yellow unit. For example:

Afternoon observations on 9/16/24 at 5:20PM revealed client #6 to sit at the dining room table to participate in the dinner meal. Continued observations revealed client #6 to hold his plate with his left hand while using his right hand to feed himself. Further observations revealed client #6 to continue to hold his plate with his left hand to prevent the plate from sliding forward.

Subsequent observations at 5:30PM revealed client #15 to sit at the dining room table and participate in the dinner meal. Continued observations revealed client #15 to hold her divided plate with her left hand to prevent the plate from sliding to the left while eating with her right hand.

Additional observations at 5:35PM revealed client #16 to sit at the dining table and participate in the dinner meal while holding her plate with her left hand and to eat with her right hand. Continued observations revealed client #16 to hold her divided plate with her left hand to prevent the

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W 436	Continued From page 16 plate from sliding forward. Morning observations on 9/17/24 at 8:15AM revealed client #15 to participate in the breakfast meal holding her divided plate with her left hand to prevent the plate from sliding. Subsequent observations at 8:20AM revealed client #16 to hold her plate with her left hand to prevent the plate from sliding and eat with her right hand during the breakfast meal. Review of the record for client #6 on 9/17/24 revealed a PCP dated 11/14/23 which did not reveal any adaptive equipment to be used during mealtimes. Continued review of the record for client #6 revealed an occupational therapy (OT) assessment dated 7/10/24 which indicated that all adaptive equipment for client #6 has been discontinued. Review of the record for client #15 on 9/17/24 revealed a PCP dated 2/27/24 and OT Assessment dated 2/1/24 revealed the client uses a spoon and a cup with a cover due to tremors. Review of the record for client #16 on 9/17/24 revealed a PCP dated 5/16/24 and an OT Assessment dated 8/19/22 which indicated the clients uses a regular spoon, cup and utensils during mealtimes. Interview with the PA on 9/17/24 revealed that clients #6, #15, and #16 use a divided dish during mealtimes. Continued interview with the PA revealed that clients #6, #15, #16 could benefit from a dycem mat to assist with improving their level of independence during mealtimes.	W 436		