PRINTED: 02/24/2025 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		()	` ′	PLE CONSTRUCTION G		B) DATE SURVEY COMPLETED	
	34G038		B. WING		C 02/17/2025		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11950 HOWELL CENTER DRIVE CHARLOTTE, NC 28227	1 021	1772023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENT	TS .	W 00	0			
W 159	intake #NC0022619 Intake #NC0022619 no deficiencies wer	was completed on 2/17/25 for 27 and intake #NC00226641. 27 was unsubstantiated and e cited. Intake #NC00226641 and deficiencies were cited.	W 15	9			
	integrated, coordinate qualified intellectual. This STANDARD is Based on record refacility failed to ensure disabilities profession.	treatment program must be ated and monitored by a disability professional whose not met as evidenced by: eview and interviews the ure the qualified intellectual onal (QIDP) coordinated, nitored the changing health The finding is:					
	revealed q-notes, we consults, nurse's not summaries indicating hospitalizations date concerns with pressum positive for E-Coli, I scratches (long jagge catheter severely kind abrasions to knuckly himself in the forendisease consult date.	rd for client #1 on 2/17/25 yound care consults, medical otes, and hospital discharge ing the client has had multiple ed from 4/1/24-current due to sure sores (stage 3 and 4), MRSA, facial bruising and ged nails), suprapubic inked, exposure to the flu, and es for repeatedly striking ead. Review of an infectious ed 9/11/24 indicated the need equent hospitalizations due to					
	2/17/25 revealed tw (shopped for Christ 1/15/25(reviewed b	of the record for client #1 on 70 q-notes dated 12/17/24 mas gift) and ehavioral data). There was no	MATURE	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
	34G038		B. WING		C 02/17/2025	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 11950 HOWELL CENTER DRIVE CHARLOTTE, NC 28227	•	1172023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	ION SHOULD BE COMPLI HE APPROPRIATE DAT	
W 159	documentation rela and no update on comedical changes at record for client #1 staff in-service train no repositioning log completed, no cathological completed, and no client #1's behavior. Interview with the diffacility administrator have not received in client #1's changing interview verified the any T-Log notes, recatheter logs. The I	tive to core team meetings coordinating care for client #1's and needs. Review of the did not reveal evidence of sing post discharge instruction, is completed, no nail care logs eter checked/changed logs staff T-Log notes relative to sor medical needs. irrector of nursing (DON) and or on 2/17/25 verified that staff in-service training to address gomedical needs. Further at staff did not document on epositioning, nail care, and DON revealed that it is the hold the did not the nurse to	W 1	59		
W 192	Interview with the QIDP on 2/17/25 revealed there have not been any interdisciplinary meetings or in-service training with staff to address the client's changing medical condition. Continued interview with the QIDP revealed that she doesn't coordinate meetings and it's the responsibility of the Nurse. Further interview verified staff did not document on any T-Log notes, repositioning, nail care, and catheter logs. The QIDP stated that she only takes the word of the staff that the clients' needs are being met and that she can't check behind every person. STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.		W 1	92		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED		
	34G038		B. WING _		C 02/17/2025		
NAME OF PROVIDER OR SUPPLIER CLEAR CREEK				STREET ADDRESS, CITY, STATE, ZIP CO 11950 HOWELL CENTER DRIVE CHARLOTTE, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 192	Based on record refailed to ensure starelative to the client needs. The finding Review of the recorrevealed wound can nurse's notes, and indicating the client hospitalizations simpressure sores. Condischarge summary client had the follow sores to the left her right foot. Review of summary dated 4/1 recommendations: two hours and wound care consult recommendations of guidelines/instruction. Subsequent review 2/17/25 revealed and dated 9/11/24 indicated summary dated 4/1 recommendations of guidelines/instruction. Subsequent review 2/17/25 revealed and dated 9/11/24 indicated summary dated 9/11/24 indicated summary dated of summ	s not met as evidenced by: eview and interview, the facility ff were sufficiently trained c's (#1) changing medical is: ed for client #1 on 2/17/25 re consults, medical consults, hospital discharge summaries has had multiple ce 4/1/24 due to concerns with ntinued review of hospital y dated 4/1/24 indicated the ving diagnoses: pressure el (stage 3), left ischium, and f the hospital discharge //24 also provided the following repositioning schedule every nd care weekly. Review of t dated 8/9/24 indicated for edema control	W 19	2			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		0.40000				С	
		34G038	B. WING		02/	/17/2025	
CLEAR C	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11950 HOWELL CENTER DRIVE CHARLOTTE, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 192	professional (QIDP completing the report two hours and char a week. Continued not verify if staff have dema control guid the level of the headay. Further interviet there have not been meetings or in-servaddress the client's PROGRAM DOCUL CFR(s): 483.440(e). Data relative to accessecified in client in	ualified intellectual disabilities) on 2/17/25 revealed staff are ositioning for client #1 every nging the dressing three times interview with the QIDP could we been trained to complete elines to elevate the legs to rt for 30 minutes, 3 times a ew with the QIDP revealed in any interdisciplinary rice training with staff to is changing medical condition. MENTATION	W 1				
	Based on record refacility failed to ensidocumented for 1 of finding is: Review of the recocomplaint investigate revealed the client hospitalizations sindiagnoses: pressur 3), left ischium, and Review of hospital a 4/1/24-1/23/25 record.	ce 4/1/24 due to the following e sores to the left heel (stage					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	COM	(X3) DATE SURVEY COMPLETED		
	34G038		B. WING		C 02/17/2025		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11950 HOWELL CENTER DRIVE CHARLOTTE, NC 28227	02/	1112023	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 252	wound care weekly guidelines. Review not reveal evidence edema control intersedent interview with the d 2/17/25 verified that repositioning accord schedule but is not interview with the D reposition the client times a week. Furth verified dressing chelectronically. Interview with the q professional (QIDP repositioning the cliit is not being tracket the QIDP verified the	of the record for client #1 did of repositioning logs and ventions as prescribed. irector of nursing (DON) on the client has been receiving ding to the facility repositioning being tracked. Continued ON revealed that staff are to and change dressings three her interview with the DON langes should be logged ualified intellectual disabilities on 2/17/25 revealed staff are ent every two hours, however ed. Continued interview with here is no formal repositioning, edema control,	W 25	22			
VV 233	are related to the cl and assessments. This STANDARD is Based on record re facility failed to door relative to body che target behaviors, af The finding is: A. Review of the re- complaint investiga		W 25				

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G038	B. WING _		02	C / 17/2025		
NAME OF PROVIDER OR SUPPLIER CLEAR CREEK				STREET ADDRESS, CITY, STATE, ZIP OF 11950 HOWELL CENTER DRIVE CHARLOTTE, NC 28227				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
W 253	12/30/23 which rev (SIBs) as a target be the record for client consult dated 12/14 scratches under the hospital discharge indicated the client from repeatedly strand head trauma. If 1/23/25 indicated the being treated for reforehead and nose bilateral mittens, ar himself in the face. Subsequent review revealed behavior of 11/10/24. Continue data indicated the call night" and "spindeter SIB behaviors available". Review not reveal an update	ealed self injurious behavior behavior. Continued review of the thindicated a physician 4/24 revealing pictures with eclient's neck. Review of the summary dated 1/17/25 also had abrasions to knuckles iking himself in the forehead Review of a nurses' note dated he client is in the hospital and edness and bruising to presence of dried blood on had client was repeatedly hitting of the record for client #1 data on 11/7/24, 11/8/24, and dreview of 11/2024 behavior client kept "knocking his face hing turtle should be used to so, but item is no longer of the record for client #1 did ted BSP since 12/30/23 and no able from 9/2024, 10/2024,	W 25	3				
	professional (QIDP client has been known himself in the face. QIDP revealed who staff should place is Interview with the County should be receiving Thursdays. Further revealed there is not is receiving nail car QIDP also revealed.	jualified intellectual disabilities () on 2/17/25 revealed the own to scratch his face and hit Continued interview with the en client scratches his skin bilateral mittens on his hands. QIDP also revealed the client g nail care weekly on interview with the QIDP to documentation to verify client re weekly. Interview with the dit could not be determined the spinning turtle to be used						

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	34G038 B. WING			_	C 02/17/2025		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 11950 HOWELL CENTER DI CHARLOTTE, NC 28227	RIVE	OZ/11//	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) DMPLETION DATE
W 253	to deter SIB behavi	ors. Additional interview with	W 2	53			
	the QIDP revealed	ors. Additional interview with it could not be determined if s been updated since					
	B. Review of the re- revealed wound car nurse's notes, and indicating the client hospitalizations date	cord for client #1 on 2/17/25 re consults, medical consults, hospital discharge summaries has had multiple ed from 4/1/24-current due to sure sores (stage 3 and 4)					
	facial bruising and s suprapubic cathete	scratches (long jagged nails), r severely kinked, and es from repeatedly striking					
	2/17/25 revealed or	of the record for client #1 on ne body check sheet dated body checks were provided					
W 255	2/17/25 verified that completed daily and after each hospital the DON stated that documenting the books.	irector of nursing (DON) on t body checks are not d that they are to be completed visit. Continued interview with t the facility could benefit from ody checks weekly or daily. TORING & CHANGE (1)(i)	W 2	55			
	least by the qualifie professional and re but not limited to sit successfully comple identified in the indi This STANDARD is Based on record re	ram plan must be reviewed at d intellectual disability vised as necessary, including, ruations in which the client has eted an objective or objectives vidual program plan. In some tas evidenced by: Eview and interview, the facility Behavior Support Plan (BSP)					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G038	B. WING	·		С	
		349036	D. WING			02/	17/2025
CLEAR (PROVIDER OR SUPPLIER CREEK			11	TREET ADDRESS, CITY, STATE, ZIP CODE 1950 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 255	Continued From partor client #1 was relater completion of Review on 2/17/25 a BSP dated 12/30/12/30/24. Continued behaviors to include assigned area, skindisrobing, opposition other's items. Furthor updated BSP additional interview on 2/17/25 confirmed no current meetings addressin NURSING SERVIC CFR(s): 483.460(c) The facility must preservices in accordate This STANDARD is Based on record refailed to ensure clied ongoing nursing sepressure sores. Fin Review of the record revealed wound can nurse's notes, and indicating the client	ge 7 viewed and revised as needed an objective. The findings is: of client #1's record revealed /23 with a target date of d review revealed target e disruptive behavior, leaving /sore picking, aggression, nal behavior, and taking er review revealed no current dressing SIBs. 5 with the facility administrator of the BSP and no core team ag SIBs for client #1. ES Divide clients with nursing nee with their needs. Is not met as evidenced by: Eview and interview, the facility and #1 receive the necessary revices to decrease or prevent ding are: Indicate the facility administrator of the strength of the	W 2	255		RIATE	DATE
	client #1 was transpappointment due to catheter was kinked	note dated 1/17/25 revealed ported from wound care high fever and urinary d; treated for candidal UTI. ital discharge summary dated					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		LE CONSTRUCTION	COMPLETED		
		34G038	B. WING	i			C 17/2025	
NAME OF PROVIDER OR SUPPLIER CLEAR CREEK				1	TREET ADDRESS, CITY, STATE, ZIP CODE 1950 HOWELL CENTER DRIVE CHARLOTTE, NC 28227	1 02.	1172020	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)) BE	(X5) COMPLETION DATE	
W 331	two hours and wour wound care consult recommendations of guidelines/instruction. Subsequent review 2/17/25 revealed and ated 9/11/24 indicational frequent howounds. Review of body check sheet of documentation related and no update on comedical changes are evidence of staff indischarge instruction completed, and no logs completed. Interview with the decomplete edema continuous complete edema continuous complete edema continuous complete edema continuous complete edema continuous c	of the following repositioning schedule every and care weekly. Review of a dated 8/9/24 indicated for edema control		331				