DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 07/24/2025

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 000	INITIAL COMMENTS A complaint survey was completed on 7/24/25 for intake #NC00232650. The complaint was unsubstantiated and deficiencies were cited.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to assure that an inquiry or investigation was initiated based on an injury of unknown origin for client #1. The finding is: During a complaint investigation at the facility on 7/24/25 review of documentation revealed on 7/10/25, client #1 was sent to the hospital by the facility nurse due to symptoms of lethargic and low blood pressure. Continued review of a nursing noted dated 7/10/25 revealed the facility nursed assessed the client and completed vital signs. The client also had an abrasion to the front lower left leg that was bleeding and applied pressure and band aid while waiting for ambulance to arrive. Further review of the nursing note did not reveal any bruises noted during her assessment of the client. The client was admitted to the hospital on 7/10/25 and is scheduled to be discharged from the hospital on 7/24/25 or 7/25/25. Subsequent review of a nursing note dated 7/10/25 revealed that a social worker from Novant	W 153	W 153 (#1) QP will ensure that All Direct Support Staff will be trained on Client #1 BSP. QP will also in-services All Direct Support Staff on reporting incidents. Program Manager and DON will in-service Train all Qualified Professional and LPN's/RN.s on incident report follow-up and for all injuries and IRIS level incidents.	

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

8/5/25

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.

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W 153		W 153		
	Continued From page 1 Hospital called and stated her concerns about bruises on the client's inner thigh and back, and wanted to know how he obtained them, and was advised by the facility nurse not sure. Additional review of the facility documents did not reveal that further discussions were conducted relative to the client's bruises. Review on 7/24/25 of an incident report dated 4/6/25 revealed client #1 had a bruise to his abdomen area. Further review of the 4/6/25 incident report revealed the following personnel were notified; nursing, administrator, legal representative, physician and social on call. Continued review of the 4/6/25 incident report revealed nursing to note that the client had a 10-inch circular bruise to the abdomen area tender to touch, called the physician, and got orders to send the client out to the emergency room for observation. Subsequent review revealed the facility qualified intellectual developmental professional (QIDP) to sign the report on 4/10/25. Additional review did not reveal additional research and/or follow up by the QIDP, or documentation related to whether this incident resulted in an inquiry or investigation. Also no documentation was provided to the surveyor for review relative to the unknown origin of the bruises. Review of the hospital discharge summary dated 4/6/25 revealed client #1's diagnosis listed as hematoma and closed fracture of one rib of right side, initial encounter. Further review of the discharge summary revealed imaging tests were completed listed as CT abdomen pelvis W IV Only, CT chest with contrast and CT head without contrast and ECG 12 lead. Labs tests were also			

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W 153		W 153		
	Continued From page 2 completed and a medication was prescribed. Review of record for client #1 on 7/24/25 revealed an admission date at the current facility of 1/6/25. Continued review revealed a person-centered plan (PCP) dated 2/11/25 with the following diagnosis of Moderate Intellectual Disability, Attention Deficit Hyperactivity Disorder, Rubinstein-Tayib Syndrome, Glaucoma, Aphonia, Tracheal Stenosis, Congenital ESOP Fistula and a history of Stroke (mid 2024). Further review of client #1's PCP revealed a behavior support plan dated 1/15/25 with the following targeted behaviors listed as aggression (pinching, pushing, hitting the wall, throwing items (water bottles, eyeglasses, cover on trach, etc), inappropriate self-stimulation and removing medical device (both actually pulling at his trach and attempts at doing so). Review of behavior data for 3/25,4/25, 6/25, 7/25 revealed the following; 7/10/25: pinching and hitting, 7/10/25: pulls off his trach and licks the mucus he pinches and hits and throw objects 7/7/25: client was hitting, 6/23/25: client was hitting staff and 6/19/25: removing medical equipment. Review on 7/24/25 of the facility's "Investigation" policy (102.058) states if the agency is assigned responsibility for conducting the investigation, the Administrator or designee will begin each investigation within 24 hours of an allegation of abuse, neglect, or exploitation, or an injury of unknown origin. Interview with the facility administrator (FA) and			

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W 153	Continued From page 3 director of nursing (DON) on 7/24/25 revealed the client does have a history of hitting walls, pinching and hitting staff, pulling out his trach, throwing objects including breaking his glasses. Continued interview with the FA and DON verified the 7/10/25 nursing note and the information relative to the concerns of the bruises were brought to their attention, however the facility could not initiate an inquiry of unknown origin because the client had been admitted to the hospital and remains there as of 7/24/25. Further interview with the FA confirmed with the 4/6/25 incident, following the client release from the hospital there were no documentation to review relative to whether an internal inquiry or investigation was initiated or confirmed. Subsequent interview with the FA confirmed the agency did not complete an inquiry or internal investigation to determine the injury of unknown origin for both incidents.	W 153		