STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562	A. BUILDING _____ B. WING _____	C 10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLEAR CREEK NURSING & REHABILITATION CENTER	10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, 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
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review and physician and staff interview, the facility failed to follow through with the treatment for a wound on the right first toe as recommended by the wound doctor for 1 of 3 sampled residents with physician ordered treatments (Resident #2). Findings included: Resident # 2 was originally admitted to the facility on 10/13/16 with diagnoses that included depression, HTN, and congestive heart failure. A care plan dated 7/11/17 revealed Resident # 2 had wounds on the right great toe and right second toe. The care plan interventions included to administer treatments to the skin as ordered by the doctor.	F 314	Clear Creek Nursing and Rehabilitation Center acknowledges the receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehabilitation Center's response to this statement of deficiencies does not denote agreement with the statement of deficiencies nor does it constitute and admission that any deficiency is accurate. Further, Clear Creek Nursing and Rehabilitation Center reserves the right to	11/7/17

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

Electronically Signed | 10/25/2017

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F 314	Continued From page 1 Record review revealed a wound care specialist evaluation note for Resident # 2 dated 8/29/17 indicated a wound on the right, first toe. The assessment and plan of care recommendation from the Wound Doctor included to add calcium alginate once daily to the treatment of the right, first toe. Record review revealed a Treatment Administration Record (TAR) for Resident # 2 dated August 2017 to cleanse the right great toe with normal saline, pat dry, apply santyl and a dry dressing daily. The treatment was signed as completed on 8/29/17 to 8/31/17. The TAR did not indicate calcium alginate was added to the treatment for Resident # 2. Record review revealed a TAR for Resident # 2 dated September 2017 to cleanse the right great toe with normal saline, pat dry, apply santyl and a dry dressing daily. The treatment was signed as completed on 9/1/17. The TAR did not indicate calcium alginate was added to the treatment for Resident # 2. On 10/10 /17 at 1:28 PM the Wound Nurse stated Resident # 2 had a wound on the right great toe and the daily treatment was to apply santyl and dry dressing. The Wound Nurse indicated Resident # 2 was seen by the Wound Doctor on 8/29/17 and his recommendation was to add calcium alginate to the daily treatment. The Wound Nurse went on to say when the Wound Doctor wrote a recommendation, the nurse working with him was supposed to transcribe the order and place on the treatment sheet. The Wound Nurse further stated she did not round with the Wound Doctor on 8/29/17 and did not	F 314	refute any of the deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceedings. Resident affected: Resident #2 was readmitted to facility 10/13/17 from hospital. On 10/13 /17 resident #2 was assessed by wound nurse. The patient was seen by the Nurse Practitioner on 10/17/2017 with review of all orders and treatments. To achieve correction for those who were or may have been affected by the alleged deficient practice the facility will conduct a 100% audit of residents receiving treatments to assure that all orders for those treatments have been properly implemented and followed through. This audit will be 100% complete by 10/25/17 by the wound nurse. To further achieve correction, On 10/25/2017 the staff facilitator began in-servicing 100% of RN's and LPN's on procedures for receiving, writing, transcribing orders and completing treatments. In-service will be 100% complete by 11/7/2017. All newly hired RN's and LPN's will receive in-service during new employee orientation. To monitor the plan of correction and assure that it is effective, Beginning 10/25/2017 The Director of Nursing or designee will begin auditing treatment order slips daily 5x/wk, along with weekly	

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F 314	Continued From page 2 know why the recommendation was not followed through. On 10/10/17 at 2:48 PM an interview with the Director of Nursing (DON) stated Resident # 2 had a wound on the right great toe. The DON stated when the Wound Doctor made a recommendation on his note, the rounding nurse was supposed to write the order and place on the treatment record. The DON verified on 8/29/17 the Wound Doctor recommended to apply santyl and add calcium alginate and dry dressing daily. The DON also stated the wound treatment for Resident # 2 from 8/29/17 to 9//1/17 did not reflect the Wound Doctor's recommendation. The DON went on to say the nurse was supposed to have changed the treatment order for Resident # 2 to include calcium alginate. The DON further stated her expectations were for the wound recommendations to be followed and transcribed correctly on the treatment record. On 10/10/17 at 3:18 PM an interview with the Wound Doctor revealed Resident # 2 was evaluated on 8/29/17 due to the wound on the right great toe. The Wound Doctor stated his recommendations were to add calcium alginate to the area daily. The Wound Doctor indicated his expectations were for the calcium alginate recommendation to be added to the daily treatment for Resident # 2. The Wound Doctor further stated there would have been no negative outcome from the omission of the calcium alginate from the treatment. On 10/10/17 at 3:40 PM the Administrator stated he expected for all the treatments to be done	F 314	treatment orders from the wound doctor's rounds. This monitoring has been added to the daily clinical start-up meeting agenda and will be ongoing. Additionally, Treatment Administration Records will now be check and signed by two nurses each month. The Director of Nursing and/or MDS Nurse will report the results of monitoring to the QAPI committee at its monthly meeting for three months and then further as deemed necessary by the committee. The Director of Nursing is responsible for implementation of the plan of correction and corrective action will be accomplished by November 7, 2017.	

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F 314	Continued From page 3 according to professional standards.	F 314		