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 04/18/2018

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 000	INITIAL COMMENTS There were no deficiencies cited as a result of the complaint investigation Event ID QMN711.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interview, and record review, the facility failed to assess the ability of a resident to self-administer an inhaler that she kept on her person and at bedside for 1 of 1 residents (Resident #310) reviewed for self-administration of medications. Findings included: Review of the facility policy titled, "Self-Administration of Medications", read in part: A. Residents who request approval to self-administer shall be assessed by the interdisciplinary team to determine if the resident is competent. B. The interdisciplinary team will assess the resident's cognitive, physical and visual ability to carry out this responsibility. Facility staff may use the sample self-administration form on the following page or a facility-developed mechanism to document this assessment. Resident #310 was admitted to the facility on 4/7/2018 with a diagnosis that included malignant	F 554	Clear Creek Nursing and Rehab acknowledges 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 residents. The Plan of Correction is submitted as a written allegation of compliance. Clear Creek Nursing and Rehab response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Clear Creek Nursing and Rehab reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F tag 554 Resident Self-Admin Meds-Clinically Appropriate	5/16/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/10/2018

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F 554	Continued From page 1 neoplasm of kidney, chronic obstructive pulmonary disease, and hypertension. Review of the Nursing Admission and Re-entry Evaluation dated 4/8/2018 revealed that Resident #310 was independent with dressing, personal hygiene, transferring, dining, and toileting. Resident #310 utilizes a rollator or wheelchair for ambulation. Resident #310 was cognitively intact, able to communicate needs and could be understood, had adequate hearing and wore corrective lenses. No behaviors indicated. Review of the Admission Minimum Data Set (MDS) dated 4/14/2018, revealed that the Admission MDS was in progress and not completed at the time of the investigation. Review of the care plan dated 4/13/2018 revealed a problem/ onset for potential or actual ineffective breathing pattern related to chronic obstructive pulmonary disease. The identified goal was that Resident #310's airway would be maintained. The interventions included administer medication as ordered by the physician and administer nebulizer treatments as ordered by the physician that identified the nurse and medication aide as responsible. Review of Resident #310's telephone physician order dated 4/7/2018 revealed an order that read, may self-administer nebulizer/ inhalers. Review of Resident #310's electronic medical record revealed no assessment for self-administering of medication. There was no documentation of the IDT assessment, approval and care plan.	F 554	The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established policy related to self- administration of medications. On 4/7/18 a physician order for resident # 310 was written for resident to self-administer nebulizer/inhalers. On 4/17/18 the staff nurse completed a medication self -administration assessment for resident # 310. On 4-17-2018, the interdisciplinary team reviewed resident #310's medication self-administration assessment and resident # 310 was deemed safe to self-administer medications. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4-17-2018, a 100% audit of residents who self-administer medications was completed by the Director of Nursing to ensure there was a physician's order and medication self-administration assessment in place. Any concerns noted during audit were immediately addressed. On 4-26-2018, the Director of Nursing began in-servicing 100% of RN's and LPN's related to the self-administration of medication policy. The in-service will be	

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F 554	Continued From page 2 An observation on 04/15/18 at 01:47 PM revealed Resident #310 self-administered her inhaler prior to going out to smoke. An observation on 04/16/18 at 11:30 AM revealed Resident #310 self-administered her inhaler while at a facility activity. On 04/17/18 at 08:42 AM an interview with Nurse #1 revealed that resident kept her inhaler on her person and at bedside. Nurse #1 indicated that Resident #310 had been assessed to self-administer medication. An observation with Nurse #1 and this surveyor of the assessments in the system, revealed that no self-administration assessment had been completed for Resident #310 to self-administer medication. Review of the care plans with Nurse #1 revealed that Resident #310 had no care plan for self-administration of medication. On 04/17/18 at 09:01 AM an interview with the Director of Nursing (DON) revealed that the process for assessing someone to self-administer medication would be for the nurse to first obtain an order from the physician, complete the self-administration assessment through Point Click Care (PCC) with the resident and care plan the resident for self-administration of medication. The DON further verbalized that her expectation regarding completing assessments and inputting assessment information are to be done at the time of the assessment. The DON verbalized that the assessment would be completed and inputted today for the Resident #310.	F 554	100% complete by 5-16-2018. If there are any nurses that are not in-serviced by 5-16-2018, they will be in-serviced before returning to work. All newly hired employees will receive in-service during new employee orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning 5-16-2018, the Director of Nursing or designee will audit new admissions to determine if resident who wishes to self-administer medications has received a physician order and had a medication self-administration assessment completed using the medication self-administration audit tool. This audit will be completed weekly x 4 weeks then biweekly x 8 weeks. The Director of Nursing or designee will present all findings at the monthly QI committee meeting. The QI committee will review the findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator or designee will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 554	Continued From page 3	F 554	The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups.	F 565		5/16/18

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F 565	Continued From page 4 §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews, the facility failed to resolve and communicate the facility's efforts to address concerns verbalized during Resident Council meetings for 5 consecutive months (November 2017, December 2017, January 2018, February 2018 and March 2018) for 7 of 7 residents that participated in the group meeting. Findings included: Review of the facility policy titled, "Resident Grievance Policy", revised on 08/30/2017, read in part: As the facility's grievance official, the Administrator is responsible for overseeing, directing, and investigating grievances in a prompt manner. The Administrator will review the results of grievance investigations for conclusion, ensure the confidentiality of grievance information, and initiate corrective measures or actions in accordance with state law if the grievance is confirmed by the facility or an outside entity having jurisdiction, i.e., state survey agency, quality improvement organization, or local law enforcement agency as indicated. The Resident Council minutes for the period November 2017 through March 2018 were reviewed and revealed the following:	F 565	F tag 565 failure to respond to group grievances and recommendations The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure on responding to group grievances identified during resident council meetings. On 4-19-2018, a resident council meeting was held with the activities director and new administrator present. Concerns from previous council meetings were addressed to include residents receiving medication on time, not having enough staff, beds not being made, linens not being changed, resident's getting up late, not having snacks available at night, and response time to concerns. The resident council were in agreement with resolutions. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4-19-2018, a resident council meeting	

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F 565	Continued From page 5 Resident Council minutes dated 11/9/2017 indicated residents had voiced concerns related to not getting their medications on time. Resident Council minutes dated 12/14/2017 indicated residents had voiced concerns related to not getting their medications on time, not enough help, and long wait times for staff response. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. Resident Council minutes dated 1/11/2018 indicated residents had voiced concerns related to not having enough nurse aides, nurse aides needing more training, nurse aides not making the beds and nurse aides not changing the linen. Under "Old Business" on the Resident Council minutes form, there was a notation that read in part: Concerns from last month, Administrator still reviewing and will let residents know the findings next meeting. Resident Council minutes dated 2/15/2018 indicated residents had voiced concerns related to nurse aides not making the bed, residents getting up late, and not having snacks at night available. There was no evidence of the facility's response to the concerns voiced during the previous meeting had been reviewed or discussed. Resident Council minutes dated 3/15/2018 indicated residents had voiced concerns related to not receiving medications on time, not having enough staff, not changing the bed linen and nurse aides not checking on the residents at night. There was no evidence of the facility's	F 565	was held with the Activities Director and administrator present. Concerns from previous council meetings were addressed to include residents receiving medication on time, not having enough staffs, beds not being made, linens not being changed, resident's getting up late, not having snacks available at night, and response time to concerns. The resident council were in agreement with resolutions. Administrator informed residents that if they wanted the Administrator and/or another department head to attend the meeting they could invite them and they would attend. By 5-9-2018, the Administrator will complete the in-service with the Activities Director and Social Worker on completing a resident concern form when concerns are discussed during resident council and giving the concern to the Administrator in a timely manner for follow-up. By 5-9-2018, the Administrator will complete the in-service with the Activities Director and Social Worker on discussing facility response to concerns from previous resident council meeting at the next meeting held. On 5-9-2018, the Administrator and designee initiated an in-service for the administrative staff on Follow Up to Resident Concerns which included: 1. When addressing resident concerns, you must include detailed information for resolution of concern to include a date. 2. Any needed audits or observations to	

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F 565	Continued From page 6 response to the concerns voiced during the previous meeting had been reviewed or discussed. On 04/17/18 at 12:00 PM an interview was conducted with the Resident Council group. 7 of 7 residents were in attendance and stated that they do not receive feedback from staff when group concerns are voiced. The Resident Council group indicated that each month they have concerns regarding not having enough staff, not receiving their medication on time, the nurse aides not changing the linen or making the beds and are still waiting on responses. The Resident Council group verbalized that the Activity Director attends each meeting and notated the Resident Council's concerns but they do not receive feedback regarding what they voiced. The Resident Council stated the facility's response to concerns voiced by the Resident Council during previous meetings was not discussed. On 04/17/18 at 05:47 PM an interview with the Activity Director (AD) was conducted, who revealed that she facilitated all Resident Council meetings and recorded the meeting minutes for the months of November 2017 through March 2018. The AD indicated that she would write up the concerns and provide them to the Administrator for review, then distribute the concerns to the appropriate department for resolution. The AD stated she did not discuss old business with the Resident Council and had no system in place to determine if prior concerns of the Resident Council were resolved. The AD revealed that the concern forms have not been turned in timely for Resident Council review and follow up.	F 565	support monitoring should be documented. This in-service was completed 5-9-2018. All newly hired employees will receive in-service during new employee orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements After each resident council meeting the Administrator and/or DON and/or Social Worker will review meeting minutes to ensure a resident concern form has been completed for concerns discussed during meeting and have been addressed and the resolution reviewed with the resident council in a timely manner to include a written response on the grievance form to include details of the follow up that occurred with a date. The Administrator or designee will present all findings at the monthly QI committee meeting. The QI committee will review the minutes of the resident council meeting monthly for 6 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator or designee will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 565	Continued From page 7 On 04/17/18 at 06:02 PM an interview with the Administrator revealed that his expectation regarding follow up to group concerns/ grievances was that all concerns are placed on a concern form, tracked and resolved. The administrative staff are expected to loop back to the resident and/ or group to see if what was implemented was working. The Administrator further stated that group concerns are to be well recorded and reviewed at the next Resident Council meeting. The Administrator revealed that upon his arrival (April 2018) to the facility, he noticed that concerns were not being followed up on. The Administrator indicated that he has started to review and address the concerns.	F 565	The title of the person responsible for implementing the acceptable plan of correction. The Social Worker is responsible for implementing the acceptable plan of correction.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the	F 578		5/16/18

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F 578	Continued From page 8 facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff and hospice social worker interviews and record review, the facility failed to transcribe and communicate an advance directive order for 1 of 14 sampled residents with advanced directives (Resident #36). The findings included: Resident #36 was admitted to the facility on 09/12/16 with an advance directive for Full Code status. [Full code is direction to implement Cardio-pulmonary resuscitation (CPR) should respirations and heartbeat stop.] Review of a nurse practitioner's order dated 10/20/17 revealed Resident #36 received admission to hospice services and a Do Not Resuscitate (DNR) order.	F 578	F tag 578 Advance Directives The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established policy related to resident advance directives. On 10/20/2017 the nurse practitioner wrote an order to change resident # 36 code status from full code to a do not resuscitate (DNR). On 4/17/18 the social worker updated resident 36’s electronic record to accurately address resident code status as a DNR. On 4/17/18 a	

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F 578	Continued From page 9 Review of a hospice social worker note dated 10/26/17 revealed documentation of confirmation with Resident #36's family member of DNR status. Review of Resident #36's quarterly Minimum Data Set dated 02/06/18 revealed an assessment of short-term and long-term memory problems. Review of Resident #36's current electronic physician's orders on 04/17/18 revealed an order for full code. Review of Resident #36's hard copy clinical record there was no form which indicated Resident #36's advance directive. Interview with the facility's social worker on 04/17/18 at 9:57 AM revealed staff used a form placed in residents' hard copy clinical record for advance directive direction. The DNR form was called a "goldenrod" because of the gold color. The facility social worker looked at Resident #36's hard copy clinical record and announced Resident #36's advance directive was full code in the absence of a goldenrod form. The social worker explained she was not aware of Resident #36's DNR order dated 10/20/17. The social worker reported the hospice social worker held responsibility to place the goldenrod in the record for staff communication. Interview with the medication aide on 04/17/18 at 9:58 AM revealed Resident #36 was a full code according to the clinical record. The medication aide reported Resident #36 would receive CPR if required.	F 578	golden rod was signed by the physician and placed in the resident 36's hard chart by the social worker to indicate the resident is a DNR. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4-18-2018, a 100% of resident electronic records and hard charts were audited by Social Worker using a census to ensure their code status was correct and that if resident is a DNR there is a physician's order and a golden rod in place. On 4-26-2018, the Director of Nursing began in-servicing the 100% of RN's and LPN's related to resident code status to include notifying the social worker when an order is received to change a resident's code status. The in-service will be 100% complete by 5-16-2018. If there are any nurses that are not in-serviced by 5-16-2018, they will be in-serviced before returning to work. All newly hired employees will receive in-service during new employee orientation. On 5-9-2018, the Administrator in-serviced the Social Worker related to the facility advance directive policy. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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F 578	Continued From page 10 Telephone interview with the hospice social worker on 04/17/18 at 10:39 AM revealed Resident #36's advance directive was DNR. The hospice social worker explained the facility was responsible for the communication of advance directives. Interview with the Director of Nursing (DON) on 04/17/18 at 10:41 AM revealed she expected advance directive information to be accurate. The DON reported Resident #36's clinical record did not contain the accurate advance directive. The DON reported Resident #36's record would receive immediate correction to accurately depict DNR status.	F 578	Beginning 5-16-2018, the Social Worker will begin auditing resident charts to ensure code status is accurate to include if the resident is a DNR that there is a physician order and golden rod in place. Ten resident records to include new admissions will be audited weekly x 4 weeks then biweekly x 8 weeks. The Social Worker will present all findings at the monthly QI committee meeting. The QI committee will review the findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator or designee will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Social Worker is responsible for implementing the acceptable plan of correction.	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 636		5/16/18

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F 636	Continued From page 11	F 636		

§483.20(b) Comprehensive Assessments
§483.20(b)(1) Resident Assessment Instrument.
A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following:
(i) Identification and demographic information
(ii) Customary routine.
(iii) Cognitive patterns.
(iv) Communication.
(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this

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F 636	Continued From page 12 chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility failed to conduct comprehensive assessments to identify and analyze how condition affected function and quality of life related to falls and psychotropic medication use; and failed to conduct assessments comprehensive assessments for 4 of 16 sampled residents who required comprehensive assessments (Residents #2, #7 #31, and #44). The findings included: 1. Resident #44 was admitted to the facility on 02/26/18 with diagnoses which included dementia. Review of Resident #44's admission Minimum Data Set (MDS) dated 03/05/18 revealed short-term and long-term memory problems. The MDS indicated Resident #44 required the extensive assistance of two person with transfers and had a fall prior to admission. The MDS indicated Resident #44 received antipsychotic	F 636	F tag 636 Comprehensive Assessments and Timing The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established procedure in timely and accurately completing the comprehensive assessments to include the Care Area Assessments (CAA's) related to falls, psychotropic medication use, pressure ulcers, urinary incontinence and indwelling catheter, communication, and visual function, . On 5-10-2018, the MDS nurse completed a detailed general care plan progress note for residents # 44, #31. The documentation for resident #44 is detailed	

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F 636	Continued From page 13 and antidepressant medications. The MDS triggered the Fall and Psychotropic Medication Use Care Area Assessments (CAA). Review of Resident #44's Fall and Psychotropic Medication Use CAAs dated 03/08/18 revealed no documentation of findings with a description of the problem, contributing factors and risk factor related to falls and psychotropic medication use. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Interview with the Director of Nursing (DON) on 04/18/18 at 10:11 AM revealed the MDS Coordinator who conducted the admission MDS dated 03/05/18 was not available for interview. The DON reported she expected staff to document a comprehensive assessment with an analysis of findings. 2. Resident #31 was admitted to the facility on 09/18/14 with diagnoses which included anxiety and hypertension. Review of Resident #31's annual Minimum Data Set (MDS) dated 02/23/18 revealed an assessment of severely impaired cognition. The MDS triggered the Fall, Pressure Ulcer, Urinary Incontinence and Indwelling Catheter, Communication and Visual Function Care Area Assessments (CAA). Review of Resident #31's Fall, Pressure Ulcer, Urinary Incontinence and Indwelling Catheter, Communication and Visual Function CAAs revealed no date completed and no documentation of findings with a description of the problem, contributing factors and risk factor	F 636	related to falls and psychotropic medication use. The documentation for resident # 31 is detailed related to falls, pressure ulcers, communication, visual function, urinary incontinence and indwelling catheter. All documentation includes a description of the focus of specific CAA triggered including causes, contributing factors, and risk factors. The documentation includes an analysis of the findings supporting the decision to proceed or not to proceed to care plan On 4/20/18, resident # 2's annual comprehensive assessment with ARD of 2/15/18 was completed by MDS Consultant to include CAAs and care plan. The completed assessment for resident #2 was transmitted to the National Repository by Ron Whitley, Clinical Quality & Reimbursement Director, and accepted on 4/20/18. On 4/19/18, resident # 7's annual comprehensive assessment with ARD of 2/21/18 was completed by MDS Consultant to include CAAs and care plan. The completed assessment for resident #2 was transmitted to the National Repository by Ron Whitley, Clinical Quality & Reimbursement Director, and accepted on 4/19/18. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5-8-2018, the MDS Coordinator began auditing each resident CAA for the past 30	

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F 636	Continued From page 14 related to falls, pressure ulcers, urinary incontinence and indwelling catheter, communication and visual function. There was no documentation of an analysis of findings supporting the decision to proceed or not to proceed to the care plan. Interview with the MDS consultant on 04/18/18 at 10:06 AM revealed Resident #31 did not receive a comprehensive assessment in the triggered areas. The MDS consultant explained the MDS coordinator responsible for Resident #31's CAAs was not available for interview. Interview with the Director of Nursing on 04/18/18 at 10:11 AM she expected staff to document a comprehensive assessment with an analysis of findings. 2. Resident #2 was admitted to the facility on 3/17/16 with diagnoses of cerebrovascular disease, transient ischemic attack, cognitive communications deficit, contracture of left shoulder, stage 2 sacral pressure and delirium due to physiological condition. On 4/16/18 the annual comprehensive Minimum Data Set (MDS) with an Assessment Reference Data (ARD) of 2/15/18 was reviewed. Sections A, B, E, G, GG, H, I, J, L, M, N, O, P and V of the MDS were still not completed. An interview with the RAI consultant and the Quality Director on 4/17/18 at 9:15am revealed the annual MDS with an ARD date of 2/15/18 for Resident #2 was not completed and was late. The MDS nurse was not available for an interview. An interview with the Director of Nursing (DON)	F 636	days to ensure all CAA's were completed accurately. A detailed general care plan progress note was completed for each resident where a concern was noted. The audit was completed on 5-9-2018. On 5-8-2018, an audit was completed by the MDS Coordinator using the MDS in progress list and MDS scheduler to identify late assessments. All late assessments will be completed by 5-16-2018. On 5/4/18, the Facility Consultant completed an in-service with the MDS Coordinator, Activities Director, Social Worker, and Dietary Manager related to timely completing assessments per the RAI manual. On 5/4/18, the facility consultant completed an in-service with the MDS Coordinator, Activities Director, Social Worker, and Dietary Manager related to when completing Section V-Care Area Assessments (CAA Summary) you must meet the requirements by describing the resident's clinical status including a description of the problem, contributing factors, risk factors, and an analysis of findings impacting care plan decisions. The analysis should include goals and interventions. Care plan and CAA should be resident specific. You should refer to the RAI manual or facility MDS consultant for questions or guidance. The monitoring procedure to ensure that the plan of correction is effective and that	

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F 636	Continued From page 15 on 4/17/18 at 10:16am revealed she was not aware the annual MDS for Resident #2 was late. The DON further stated it was her expectation that all assessments be completed by the time they were due. An interview with the Administrator on 4/18/18 at 9:07am revealed he was aware that MDS assessments were behind. He further stated he brought in the RAI consultant and the Quality Director last week to help get the MDS assessments caught up. 3. Resident #7 was admitted to the facility on 7/15/2016 with a diagnosis that included heart failure, hypertension, and Alzheimer's disease. Review of the Minimum Data Set (MDS) on 4/18/2018 revealed that an annual comprehensive MDS with an assessment reference date (ARD) of 2/21/2018 had not been completed. An interview on 4/18/2018 at 11:54am with the MDS Consultant revealed that the annual comprehensive assessment had not been completed. Her expectation was that staff follow the Resident Assessment Instrument (RAI) manual and assessments are completed timely. The MDS nurse was not available for interview. An interview on 4/18/2018 at 3:33pm with the Administrator revealed that his expectations were that MDS assessments are completed timely.	F 636	specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 5-16-2018, the Director of Nursing or designee will begin auditing the comprehensive assessments to include the CAA's using the MDS Audit Tool to ensure they are completed timely and accurately. This audit will be completed weekly x four weeks then biweekly x eight weeks by the Director of Nursing or designee. On 5-16-2018, the Director of Nursing or designee will begin monitoring the MDS assessments to ensure all parts of assessments are completed on or before due date using the MDS audit tool. The Director of Nursing or designee will audit assessments weekly for 4 weeks, then biweekly for 8 weeks. The MDS Coordinator or designee will present all findings from the MDS audit tool at the monthly QI committee. The monthly QI committee will review the results of the MDS Audit Tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator or designee will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	

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F 636	Continued From page 16	F 636	The title of the person responsible for implementing the acceptable plan of correction. The MDS Coordinator is responsible for implementing the acceptable plan of correction.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		5/16/18

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F 655	Continued From page 17 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to develop a baseline care plan for self-administration of an inhaler by 1 of 1 residents (Resident #310) reviewed for self-administration of medication baseline care plan. Findings included: Resident #310 was admitted to the facility on 4/7/2018 with diagnoses that included malignant neoplasm of kidney, chronic obstructive pulmonary disease, and hypertension. Review of Resident #310's admission physician's orders revealed an order dated 4/7/2018 that read, may self-administer nebulizer/ inhalers. Review of Resident #310's electronic medical record revealed base line care plans dated 4/9/2018 for problems/ onset of: Risk for Falls, Advanced Directives, Hospice Care due to Cancer, Activities of Daily Living/ Personal Care, Resident is an Independent and Safe Smoker,	F 655	F tag 655 Baseline Care Plan The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established policy related to development of the baseline care plan. On 5-8-2018, resident #310's care plan was updated to address self-administration of inhaler/nebulizers by MDS Coordinator. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5-8-2018, the Director of Nursing conducted an audit of the baseline care plans of each resident who	

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F 655	Continued From page 18 and Resident Care Guide. Further review of Resident #310's electronic medical record revealed no care plan for self-administering of medication. An observation on 4/15/18 at 1:47 PM revealed, prior to going out to the designated smoking area, Resident #310 took her inhaler out of her basket and self-administered her inhaler in the resident common area with no nursing supervision. Resident #310 placed the inhaler back in her basket on her rollator after she had taken two inhalations. An observation on 4/16/18 at 11:30 AM revealed Resident #310 dancing at the resident birthday party. Resident #310 then took her inhaler out of her basket on her rollator and self-administered two inhalations without being supervised by nursing. She placed the inhaler back in her basket on her rollator. An interview with Resident #310 on 4/16/18 at 1:30 PM revealed that she always had her inhaler on her. Resident #310 verbalized that she had breathing problems and her oxygen didn't always work due to her lung capacity. Resident #310 indicated that when she felt short of breath, she would use her inhaler. She did not recall being assessed by staff to self-administer the inhaler, nor did she inform the staff of how often she used the inhaler throughout the day. On 04/17/18 at 8:42 AM an interview with Nurse #1 revealed she was the assigned nurse for Resident #310. Nurse #1 indicated that Resident #310 kept her inhaler on her person since she was admitted. Nurse #1 revealed that no self-administration assessment had been	F 655	self-administers medication in order to ensure that they included initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, and PASARR recommendations if applicable. On 5-8-2018, a 100% audit of the care plans of each resident who self-administers medication to ensure self-administration of medication is present and accurate in care plan. On 5-9-2018, the MDS Coordinator began in-servicing 100% of RN's and LPN's related to notifying the interdisciplinary team (IDT) when an order is received for resident to self-administer medications. The in-service will be 100% complete by 5-16-2018. If there are any of these employees that are not in-serviced by 5-16-2018, they will be in-serviced before returning to work. On 5/4/18 the facility consultant in-serviced the IDT related to the development of baseline care plans within 48 hours of resident admissions to include if the resident has an order, is assessed, and deemed safe to self-administer medications; this must be included in resident's baseline care plan. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements	

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F 655	Continued From page 19 completed for Resident #310 to self-administer medication. Review of the care plans with Nurse #1 revealed that Resident #310 had no care plan for self-administration of medication. Nurse #1 indicated that initial care plans are in Point Click Care (PCC) and can be implemented immediately until administration reviews. The MDS Nurse was not available for interview. On 04/17/18 at 9:01 AM an interview with the Director of Nursing (DON) revealed that her expectation was that the baseline care plan should be in Point Click Care (PCC) and completed within the designated timeframe.	F 655	Beginning 5-16-2018, the Director of Nursing or designee will begin auditing new admissions using the baseline care plan audit tool to ensure a baseline care plan has been developed and if resident self-administers medication is included in the base line care plan. This audit will be completed 5x/week x 4 weeks, then once weekly x 8 weeks. The MDS Coordinator or designee will present all findings at the monthly QI committee meeting. The QI committee will review the findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator or designee will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The MDS Coordinator is responsible for implementing the acceptable plan of correction.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-	F 657		5/16/18

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F 657	Continued From page 20 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to revise a care plan related to positioning for 1 of 4 sampled residents who required assistance with positioning (Resident #48). The findings included: Resident #48 was admitted to the facility on 12/21/16 with diagnoses which included Alzheimer ' s Disease. Review of an occupational therapy discharge	F 657	F tag 657 Care Plan Timing and Revision The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow established policy related to revision of the resident care plan/guide. On 5-10-2018, resident #48’s care	

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F 657	Continued From page 21 summary dated 05/03/17 revealed Resident #48 received an assessment to determine a seating system to increase comfort, provide safety and decrease agitated behaviors. Resident #48's wheel chair was changed to a brand specific tilt chair with a 4-quadrant gel cushion. Review of Resident #48's quarterly Minimum Data Set (MDS) dated 02/17/18 revealed an assessment of short-term and long-term memory problems. The MDS indicated Resident #48 required the extensive assistance of one person with bed mobility and transfers. Review of the care plan dated of 03/14/18 revealed Resident #48 required the assistance of one person with transfers. There was no documentation of a chair type. Observation on 04/15/18 at 9:07 AM revealed Resident #48 seated in a wheelchair on a pommel cushion. (A pommel cushion is a cushion with an upward projecting protuberance at the front.) Resident #48's toe tips reached the floor. The wheel chair did not contain leg rests. Resident #48 moved both legs knee to chest. Observations on 04/15/18 at 9:64 AM and 10:19 AM revealed Resident #48 seated on the pommel cushion in the wheelchair. Observation at 10:48 AM on 04/15/18 revealed Resident #48 with both legs on the right side of the pommel cushion center. Both legs dangled off the chair. Observations on 04/16/18 at 8:49 AM revealed Resident #48 seated on the pommel cushion in the wheelchair. Observations at 9:23 AM, 9:44 AM, and 10:56 AM on 04/16/18 revealed Resident #48 seated in the same position; the	F 657	plan/care guide was updated by MDS Coordinator to address positioning, type of wheelchair, and wheelchair cushion. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 5-16-2018, MDS Coordinator will begin auditing a 100% of resident care plans/guides to ensure that resident care plans/guides were accurate to include interventions for residents who required assistance with positioning. Care plans/guides were updated as needed. On 4-26-2018, the Director of Nursing and Therapy Department began in-servicing the 100% of RN's, LPN's, and therapy staff related to notifying the interdisciplinary team (IDT) when there is a change related to resident care to include positioning and/or positioning devices. The in-service will be 100% complete by 5-16-2018. All newly hired employees will receive in-service during new employee orientation. On 5/4/18 the facility consultant in-serviced the IDT related to the revision of care plans. The in-service includes that the care plan/guide will be updated routinely with completion of each comprehensive and quarterly MDS assessment as well as upon any change in resident's condition to include implementation of interventions related to positioning including specialty wheelchairs and cushions when appropriate.	

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	345562	A. BUILDING _____ B. WING _____	C 04/18/2018

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F 657	Continued From page 22 pommel cushion overlapped the wheel chair seat approximately 2 inches. Interview on 04/16/18 at 2:38 PM with Nurse Aide (NA) #1 revealed Resident #48 used the wheel chair and pommel cushion every day when out of bed. NA #1 explained Resident #48 required total assistance with locomotion and moved her legs frequently over the center of the pommel cushion. Interview with Nurse #2 on 04/16/18 at 4:00 PM revealed Resident #48 used the wheel chair with pommel cushion daily. Nurse #2 reported she was not aware of another tilt chair with 4-quadrant gel cushion for Resident #48's use. Interview on 04/17/18 at 8:41 AM with NA #2 revealed Resident #48 used the wheel chair and pommel cushion every day when out of bed. Interview with the Director of Nursing (DON) on 04/18/17 at 10:12 AM revealed the MDS Coordinator was responsible to revise care plans. The Don reported the MDS Coordinator was not available for interview. The DON stated she expected care plans to be revised as needed. The DON reported Resident #48's care plan did not accurately document interventions for care.	F 657	The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements Beginning 5-16-2018, the MDS Coordinator will begin auditing resident care plans/guides have been revised when there is a change in positioning, specialty wheelchair, and or wheelchair cushion using the positioning audit tool. Ten resident care plans/guides will be audited weekly x 4 weeks then biweekly x 8 weeks. The MDS Coordinator or designee will present all findings at the monthly QI committee meeting. The QI committee will review the findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator or designee will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The MDS Coordinator is responsible for implementing the acceptable plan of	

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F 657	Continued From page 23	F 657	correction.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observations, staff and hospice nurse interviews, and record review, the facility failed to provide the appropriate size of wheel chair for proper body alignment for 1 of 4 sampled residents who required assistance with positioning (Resident #48). The findings included: Resident #48 was admitted to the facility on 12/21/16 with diagnoses which included Alzheimer's Disease. Review of an occupational therapy discharge summary dated 05/03/17 revealed Resident #48 received an assessment to determine a seating system to increase comfort, provide safety and decrease agitated behaviors. Resident #48's wheel chair was changed to a brand specific tilt chair with a 4-quadrant gel cushion. Review of Resident #48's quarterly Minimum Data Set (MDS) dated 02/17/18 revealed an	F 684	F tag 684 Quality of Care The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation center regarding the process that lead to this deficiency was the staff failure to follow the facility established protocol related residents who require assistance with positioning. On 4-18-2018, resident #48 was referred to therapy to address positioning, type of wheelchair, and wheelchair cushion. On 4-19-2018, resident # 48 was placed in a Broda chair with a gel cushion and foot rest to ensure the resident was in an upright position and feet were not dangling. On 5-2-2018, resident #48 was again referred to therapy to address positioning, type of wheelchair, and wheelchair cushion. On 5-9-2018, after	5/16/18

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F 684	Continued From page 24 assessment of short-term and long-term memory problems. The MDS indicated Resident #48 required the extensive assistance of one person with bed mobility and transfers. Review of the care plan dated of 03/14/18 revealed Resident #48 required the assistance of one person with transfers. There was no documentation of a chair type. Review of Resident #48's resident care guide dated 03/21/18 and posted inside Resident #48's closet revealed required equipment included the brand specific tilt chair with a 4- quadrant gel cushion when out of bed. Observation on 04/15/18 at 9:07 AM revealed Resident #48 seated in a wheelchair on a pommel cushion. (A pommel cushion is a cushion with an upward projecting protuberance at the front.) Resident #48's toe tips reached the floor. The wheel chair did not contain leg rests. Resident #48 moved both legs knee to chest. Observations on 04/15/18 at 9:64 AM and 10:19 AM revealed Resident #48 seated on the pommel cushion in the wheelchair. Observation at 10:48 AM on 04/15/18 revealed Resident #48 with both legs on the right side of the pommel cushion center. Both legs dangled off the chair. Observations on 04/16/18 at 8:49 AM revealed Resident #48 seated on the pommel cushion in the wheelchair. Observations at 9:23 AM, 9:44 AM, and 10:56 AM on 04/16/18 revealed Resident #48 seated in the same position; the pommel cushion overlapped the wheel chair seat approximately 2 inches.	F 684	further evaluation, resident #48 was placed in high back reclining wheelchair with leg rests, footboard, and low profile cushion. The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4-17-2018, the Director of Nursing began auditing a 100% of residents to ensure they are positioned upright in the appropriate size wheelchair with appropriate cushion and feet are not dangling. The audit will be 100% complete by 5-16-2018. All concerns found during audit were immediately addressed with a referral to therapy. On 4-26-2018, the Director of Nursing and Rehab Director began in-servicing the 100% of RN's, LPN,s, CNA's, medication aides, and therapy staff related to appropriate resident positioning to include resident be positioned upright in the appropriate size wheelchair with appropriate cushion and the resident's feet should not be dangling. The in-service will be 100% complete by 5-16-2018. If there are any of these employees that are not in-serviced by 5-16-2018, they will be in-serviced before returning to work. All newly hired employees will receive in-service during new employee orientation. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected	

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F 684	Continued From page 25 Interview on 04/16/18 at 2:38 PM with Nurse Aide (NA) #1 revealed Resident #48 used the wheel chair and pommel cushion every day when out of bed. NA #1 explained Resident #48 required total assistance with locomotion and moved her legs frequently over the center of the pommel cushion. Interview with Nurse #2 on 04/16/18 at 4:00 PM revealed Resident #48 used the wheel chair with pommel cushion daily. Nurse #2 reported she was not aware of another tilt chair with 4-quadrant gel cushion for Resident #48's use. Interview on 04/17/18 at 8:41 AM with NA #2 revealed Resident #48 used the wheel chair and pommel cushion every day when out of bed. Observations on 04/17/18 at 8:50 AM revealed Resident #48 seated on the pommel cushion in the wheelchair. Observations at 9:43 AM on 04/17/18 revealed Resident #48 seated in the same position; the pommel cushion overlapped the wheel chair seat approximately 2 inches. Resident #48 placed both hands on the protuberance in the center of the pommel cushion. Interview with the rehabilitation director (RD) at 10:08 AM on 04/17/18 revealed Resident #48 received a discharge from therapy with the direction to use the brand specific tilt chair and 4-quadrant gel cushion. Upon observation of Resident #48 seated in the wheel chair on the pommel cushion, the RD announced the wheel chair was not at the correct height for Resident #48. The RD explained the pommel cushion should not overlap the edge of the wheel chair. The RD suggested the hospice staff might have switched out the chairs.	F 684	and/or in compliance with the regulatory requirements Beginning 5-16-2018, the Director of Nursing or designee will begin auditing residents to ensure they are positioned upright in the appropriate size wheelchair with appropriate cushion and feet are not dangling using the positioning audit tool. Ten residents will be audited weekly x 4 weeks then biweekly x 8 weeks. The Director of Nursing and/or designated will present all findings at the monthly QI committee meeting. The QI committee will review the findings for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The Administrator or designee will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The title of the person responsible for implementing the acceptable plan of correction. The Director of Nursing is responsible for implementing the acceptable plan of correction.	

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F 684	Continued From page 26 Interview with the Director of Nursing (DON) on 04/17/18 at 10:44 AM revealed Resident #48 should be properly positioned and could not provide a reason the recommended chair and cushion was not used. Telephone interview with the hospice nurse on 04/17/18 at 12:09 PM revealed Resident #48 "probably" received a new chair when hospice services began May 2017. The hospice nurse explained the hospice relied on facility staff to assess positioning needs such as wheel chair height and cushions since Resident #48 was usually in bed during hospice visits.	F 684		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor these interventions that the committee put into place 04/24/2017. This was a recite for the deficiency cited in 03/01/2017. The deficiency was in the area of Care Area Assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867	F tag 867 QAPI/QAA Improvement Activities The plan of correcting the specific deficiency The position of Clear Creek Nursing and Rehabilitation Center regarding the process that lead to this deficiency was failure to follow established facility policy related to QAPI.	5/16/18

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F 867	Continued From page 27 Findings include: This tag is cross referenced to: F636 Care Area Assessments: Based on staff interviews and record review the facility failed to conduct comprehensive assessments to identify and analyze how condition affected functions and quality of life related to falls and psychotropic medications use; and failed to conduct assessments comprehensive assessments for 4 of 16 sampled residents who required comprehensive assessments (Residents #2, #7, #31, and #44). The facility was recited for F636 (F 272) originally cited on 03/01/2017 for Care Area Assessments of cognitive patterns, mood and behavior patterns and health related to pain. The plan put in place on 04/24/2017 was not maintained and subsequently was recited on the current recertification survey on 04/18/2018. During an interview on 04/18/2018 at 03:50 PM the Director of Nursing and Administrator stated they completed the correction and were in compliance. We expect to be in compliance with our Care Area Assessments.	F 867	The procedure for implementing the acceptable plan of correction for the specific deficiency cited On 4-26-2018, the facility QAA Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Medical Director, Administrator, DON, MDS nurse, Dietary Manager, maintenance director, medical records, and housekeeping supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 5-4-2018, the corporate facility consultant in-serviced the facility administrator, director of nursing, MDS nurse, admissions, activities director, maintenance director, dietary manager, medical records, therapy director, and housekeeping supervisor related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to Comprehensive Assessments and Care Area Assessments. As of 5-16-2018, the facility QAPI Committee will begin identifying other areas of quality concern through the QI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (Electronic Medical Record), review of resident council minutes, review of resident concern logs, review of pharmacy reports,	

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F 867	Continued From page 28	F 867	review of audits related to the plan of correction and review of regional facility consultant recommendations. The Facility QAPI Committee will meet at a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to MDS accuracy, Comprehensive Assessments, and Quality Assurance. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements The executive QAPI committee will continue to meet at a minimum of Quarterly, and QAPI committee monthly with oversight by a corporate staff member. The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility's progress in correction of deficient practices or identify concerns. The Administrator will be responsible for	

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F 867	Continued From page 29	F 867	ensuring Committee concerns are addressed through further training or other interventions. The title of the person responsible for implementing the acceptable plan of correction The Administrator is responsible for implementation of the acceptable plan of correction.	