PRINTED: 07/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		24550	D WING			С
NAME OF D	ROVIDER OR SUPPLIER	345562	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE	(05/31/2018
NAME OF PI	ROVIDER OR SUPPLIER			10506 CLEAR CREEK COMMERCE DRIVE		
CLEAR C	REEK NURSING & REHA	ABILITATION CENTER		MINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F 0	00		
	1. 483.10 (F580) at	J.				
	Resident #1 began to droop, slurred speech not assess the resident therefore did not reported therefore did not reported the medical provider Immediate Jeopardy 5:53 PM when the fairmplemented an accellimmediate Jeopardy remains out of completed the severity of a D (no accompleted the severity of a D (no accompleted the severity of a D) to complete monitoring systems provided the severity of a D (no accompleted the severity of a D) to complete monitoring systems provided the severity of a D (no accompleted the severity of a D) to complete monitoring systems provided the severity of a D (no accompleted the severity of a D) to complete monitoring systems provided the severity of a D) to complete monitoring systems provided the severity of a D (no accompleted the severity of a D) to complete monitoring systems provide	was removed on 05/31/18 at cility provided and eptable allegation of				
	2. 483.25 (F684) at 3	J				
	Resident #1 began to of a stroke that included a stroke that included a side facial droop, and notified by various start was exhibiting slut facial droop, and droop and droop and droop and the sident #1. Immediate on 05/31/18 at 5:53 Fand implemented an immediate jeopardy rout of compliance at of a D (no actual harm than minimal harm the jeopardy) to complete	pegan on 05/11/18 when on exhibit signs and symptoms and slurred speech, right and drooling. Nurse #1 was aff and visitors that Resident when the facility provided acceptable allegation of the moval. The facility remains a lower scope and severity moves with potential for more at is not immediate the education and ensure out into place for assessing a				
ABORATORY	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUF	RE	TITLE		(X6) DATE

Electronically Signed 06/22/2018

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345562	B. WING			05/	31/2018
	ROVIDER OR SUPPLIER REEK NURSING & REHA	BILITATION CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 0506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227		
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F 000	Continued From page resident with a chang	e 1 e in condition are effective.	F	000			
	A revisit was conduct 05/31/18 and the facil compliance. Event IE	lity remains out of					
F 500	facility's follow-up and survey from 05/29/18 HCFX11.	vas conducted as part of the d complaint investigation to 05/31/18. Event ID#		5 00			6/20/40
F 580 SS=J	CFR(s): 483.10(g)(14	jury/Decline/Room, etc.))(i)-(iv)(15)	F	580			6/29/18
	consult with the reside consistent with his or representative(s) when (A) An accident involves results in injury and his physician intervention (B) A significant chan mental, or psychosocideterioration in health status in either life-throllinical complications (C) A need to alter treatment due to advect the commence a new form (D) A decision to transport the commence of the comme	ediately inform the resident; ent's physician; and notify, her authority, the resident en there is- ving the resident which as the potential for requiring u; ge in the resident's physical, ial status (that is, a a, mental, or psychosocial reatening conditions or u); eatment significantly (that is, an existing form of erse consequences, or to m of treatment); or esfer or discharge the					

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	ROVIDER OR SUPPLIER REEK NURSING & REHA	ABILITATION CENTER	•	10	TREET ADDRESS, CITY, STATE, ZIP CODE 0506 CLEAR CREEK COMMERCE DRIVE IINT HILL, NC 28227	, , ,	
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F 580	resident and the resident when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must update the address (iphone number of the representative(s). §483.10(g)(15) Admission to a composite di §483.5) must discloss its physical configural locations that compripart, and must specif room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on observation visitors, family, Nurse Doctor interviews the resident's responsible that the resident begastured speech and distroke. The facility als responsible party of a ordered to treat a urin of 3 residents reviews (Resident #1).	also promptly notify the dent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ons as specified in paragraph or record and periodically mailing and email) and	F	580	Clear Creek Nursing and Rehab acknowledges receipt of the Statement Deficiencies and proposes this Plan of Correction to the extent that the summor of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care or 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 agreeme with the Statement of Deficiencies nor does it constitute an admission that any	ary der of	

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F 580	F 580 Continued From page 3		F 58	30			
F 580	droop, slurred speed not assess the reside therefore did not repher medical provider Immediate Jeopardy 5:53 PM when the faimplemented an accommediate Jeopardy remains out of compseverity of a D (no amore than minimal hopardy) to complemonitoring systems resident's change in The findings included Resident #1 was rea 09/18/14 with diagnon hypertension and de Review of Resident assessment dated 0 was cognitively impassistance with her a (ADLs). The MDS fuclear speech and was others. On 05/29/18 at 6:30 conducted with a Restated that on 05/11/she was weighing Restated was not acting life.	h and drooling. Nurse #1 dident's change in condition and ort the change in condition and ort the change in condition to or responsible party. was removed on 05/31/18 at cility provided and eptable allegation of removal. The facility liance at a lower scope and ctual harm with potential for arm that is not Immediate the education and ensure out into place for reporting a condition were effective. d: dmitted to the facility on uses which included mentia. #1's most recent mum Data Set (MDS) 2/23/18 revealed that she ired and required limited activities of daily living rither indicated that she had is usually understood by PM an interview was storative Aide (RA) who 18 at approximately 1:00 PM esident #1 when she noticed ke herself. The RA stated	F 58	deficiency is accurate. Further Creek Nursing and Rehab reright to refute any of the deficithis Statement of Deficiencies Informal Dispute Resolution, appeal procedure and/or any administrative or legal process. F580 Notification of Changes 1. The plan of correcting the deficiency. The plan should a processes that led to the deficiency. The plan should a processes that led to the deficiency was to be the facility's failure to not family/physician/nurse practite Resident #1's change of condition and drooling. 2. The procedure for imple acceptable plan of correction specific deficiency cited On 5/10/18, the MDS nurse's General Note indicated Resident #1 with facial drooping or oth condition.	serves the siencies on sthrough formal other eding. The specific address the ciency cited sing and aced into PM for failing the process determined otify the sioner of dition when facial sementing the for the second side of the second second side of the second second side of the second se		
	she pushed her to N Nurse of what she ha	h was slurred and muffled so urse #1 and informed the ad observed of Resident #1 ted she was aware of		On 5/11/18 earlier in the day AM, Nurse #1 did observe Rechange in clarity of ZC speed not see any facial drooping o	esident #1's ech, but did		

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F 580	Continued From p	page 4	F 5	580			
	Resident #1's con	dition and the Nurse pushed		and then called the nurse pra	actitioner to		
	Resident #1 towar	rds her room.		verify the nurse practitioner v	would be at		
				the facility on 5/11/18. Nurse			
	An interview was	conducted with Visitor #1 on		licensed practical nurse (LPN			
		PM who stated she was a daily		in the scope of practice for a	n LPN to		
		ty and was familiar with how		assess.			
		ally acted. Visitor #1 stated that			44 40 414		
		proximately 2:45 PM she		On 5/11/18 at approximately			
		#1 was rolling herself around in ing her legs and flailing her		the physician extender nurse (NP) note indicated Resident	•		
		d hollering but nothing she said		by the NP. The NP note indi			
		Visitor stated Resident #1's		"Patient seen for acute care.			
		to one side (she could not		notes reviewedalert, confu			
		side) and she was drooling.		reviewed, + for leukocytes, p			
		o Nurse #1 that she thought		nitratespatient refuses PO			
	Resident #1 was I	having a stroke and Nurse #1		give Rocephin 1 gram IM q2	4h x 3 doses,		
	told Visitor #1 the	y were taking care of it.		give with lidocaine." The NP	note did not		
				indicate Resident #1 with rig	nt facial		
		10 PM an interview was		drooping.			
		sitor #2 who stated she too was		On 5/11/18 at approximately			
		ne facility and knew the		restorative aide noticed Resident #1's			
		dent #1. The Visitor stated she		speech was not clear while v	• •		
		lity around 5:00 PM on 05/11/18 sident #1 in her wheelchair		and took the resident to Nurs	e #1.		
		of noises but her speech was not		On 5/11/18, at approximately	/ 1:00 PM the		
		sitor #2 further stated that		restorative aide witnessed N			
	_	slurring her speech, had facial		looking at Resident #1 and w			
		ooling. The Visitor stated she		Nurse #1 transport Resident			
		d could not find a staff member		nurse station for observation			
		ern to so she went toward the		did not document an assessi			
	•	her way to the lobby she saw		electronic health record. No	t recognizing		
	two therapy staff i	n the therapy gym and went to		there was a change of condi-	lion, LPN #1		
		ns to them. Visitor #2 stated		did not notify a registered nu			
		n of her observation of the		nurse practitioner (NP), or ph			
		rooling and facial droop that		to re-assess Resident #1 in t			
		having, they immediately went		as the day progressed on 5/	11/18.		
	to check on her th	iemselves.		0.54440	0.45.004		
	An interview was	conducted with PT #1 and PT		On 5/11/18 at approximately different resident's family me			

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		345562	B. WING			C 5/31/2018	
NAME OF PE	ROVIDER OR SUPPLIER	1	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		5/31/2016	
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CLEAR CF	REEK NURSING & REHA	ABILITATION CENTER		MINT HILL, NC 28227	_		
0(1) 15	CHMMADVC	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF COR	PECTION	0/5)	
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F 580	Continued From pag	e 5	F 58	0			
	05/11/18 at approxim came into the therap that Resident #1 had and was drooling. Bo check on Resident #	30 PM. PT #1 stated that on lately 5:30 PM Visitor #2 by gym and reported to them slurred speech, facial droop with PT #1 and PT #2 went to 1 and found her to have the Visitor #2 reported to them.		reported that she attempted to Nurse #1 regarding Resident # #1 stated she could not recall to visitor interaction. On 5/11/18 after 5:00 PM, the reported to Nurse #1 that Resi	#1. Nurse this specific therapist		
	PT #1 and PT #2 we to Nurse #1 who stat	nt to report their observation ed, Resident #1 was seen by er (NP) earlier that day and		was exhibiting slouched postur and slurred speech. Nurse #1 NP assessed the resident in the and Resident #1 was on antibition for a urinary tract infection.	re, drooling stated the ne morning otic therapy		
	morning of 05/11/18 to evaluate Resident wrong with her. The evaluate Resident #1 "spry" self. Then she (analysis of urine) whhad a UTI so she ord The NP stated that Rigns or symptoms of slurred speech, facial would have sent her	PM an interview was IP who stated that on the she was asked by Nurse #1 #1 because something was NP stated she went to and she was not her normal reviewed her urinalysis nich indicated Resident #1 Ilered an antibiotic for her. resident #1 did not show any f a stroke for example I droop or drooling or she to the emergency room. The		On 5/11/18 at approximately 6 Nurse #1 administered an anti injection for Resident #1. At the Nurse #1 did not note observint drooping or drooling. On 5/11/18 at the 7 PM shift of Nurse #1 reported to medication (MA) #1. Nurse #1 and MA #1 report to a registered nurse (R #1's change in condition (right drooping, drooling, and continus speech) for assessment, failing established policy.	biotic nat time, ng facial nange, on aide I did not N) Resident facial ued slurred		
	around 5:00 PM and to any other changes On 05/29/18 at 5:20 conducted with Nurse throughout the day s of Resident #1's slundrooling but she felt that the NP diagram day. Nurse #1 admitt #1's responsible part	at no time was she alerted in Resident #1. PM an interview was e #1 who indicated that taff and visitors informed her red speech, facial droop, and they were the effects of the mosed her with earlier that ted she did not call Resident y (RP) nor did she notify the #1's right side facial droop,		On 5/12/18 at approximately 1 registered nurse (RN) #1 asse Resident #1. The assessment Resident #1 had a change in c (right facial drooping). RN #1 Resident #1's physician/nurse provider. The provider gave a send Resident #1 to the emerg department (ED) for evaluation also contacted Resident #1's r representative (RR)/daughter. sent Resident #1 to the ED as the provider. The RR met Resident #1 to the RR met RR me	ssed t revealed condition contacted practitioner n order to gency n. RN #1 resident RN #1 ordered by		

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CLEAR C	REEK NURSING & REHA	ABILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIV	, <u>C</u>		
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F 580	Continued From page	e 6	F 58	30			
				the ED. The resident			
	An interview was con	ducted with Nurse Aide #1		representative/daughter repor	ted to ED		
		PM. NA #1 stated she took		physician that Resident #1 wa			
		on 05/11/18 on first and		baseline on 5/10/18. The resi			
		ated that Resident #1 was		representative/daughter also r			
		f, her speech was slurred		noticing right facial drooping of	•		
	_	from one side of her mouth.		morning of 5/12/18.			
	_	eported her observation to					
	Nurse #1 and was to	ld that Resident #1 had		On 5/12/18 through 5/16/18, the	he ED		
		ed by the NP and was being		physician evaluation, including	g laboratory		
		#1 stated that she put		and radiology test results indic			
		ed per her usual routine and		evidence that Resident #1 had			
		ft at 11:00 PM on 5/11/18		cerebrovascular (CVA), "Work	•		
		ing in bed with her eyes		far has been normal except th			
	closed.			she has been hypertensive, w			
	An interview was sen	ducted with NA #2 on		started on antibiotics for her u			
		1, she confirmed that she		infections yesterday." On 5/12 physician orders were given to			
		05/11/18 and stated that		Resident #1 back to the facility			
		bed the entire night and		medications ordered. The dis			
		ything different with her. The		diagnoses of CVA, DNR, dem	-		
		red incontinent care to		hyperlipidemia, and hypertens			
	Resident #1 at appro	ximately 5:00 AM on		listed on the hospital discharg			
	05/12/18 and during	the interaction she did not		Resolved diagnosis included a	acute cystitis		
		ehavior or anything out of the		without hematuria. On 5/16/1	8, Resident		
		#1. She stated that if she had		#1 returned to the facility with	-		
	, ,	ormal with Resident #1, she		instruction for hospice evaluat	ion.		
	would have notified the	he nurse.					
	A :	dusted with Norse #0 an		3. The monitoring procedure			
		ducted with Nurse #2 on		that the plan of correction is e			
		I who confirmed he worked and was responsible for		that specific deficiency cited re corrected and/or in complianc			
		rse stated that during report		regulatory requirements	C WILLI LITE		
		Resident #1 had not been		Togulatory requirements			
		t had been evaluated by the		On 5/30/18, the minimum data	a set (MDS)		
	_	on an antibiotic for a UTI.		RN and wound nurse RN asse			
	Nurse #2 stated that			resident. The RN assessmen			
		and he never had to interact		resident included taking vital s			
		e added that NA #2 did not		and mental status for change			

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F 580	Continued From pag	e 7	F 58	0			
	that evening and it w Resident #1. An interview was cor 05/31/18 at 1:01 PM	nducted with Nurse #3 on who confirmed she worked		The purpose of the assessmer protect Resident #1 and other similar situations. The findings assessments: no current facili have a new/previously unident in condition requiring additional	residents in of the ity residents ified change al		
	Resident #1. The Nu	and was responsible for rse stated that approximately t1's RP approached her and		assessment or physician/NP/re representative notification.	esident		
	because something of stated that she had return the family asking her when she went to ob-	ne resident's vital signs wrong with her. Nurse #3 not seen Resident #1 prior to to check her vital signs but tain Resident #1's vital signs y drooling or facial droop.		On 5/30/18, the director of nur- initiated a re-education with all staff to include nursing assista MAs, LPNs, and RNs. The re- covered the topic of "Notification	I nursing nts (NAs), -education		
	Nurse #3 stated she and she did then she arms in the air which stated that her asses in Resident #1 from I requested for her to	asked Resident #1 to smile asked her to raise both she did as well. Nurse #3 asment revealed no change her baseline but the RP be sent to the Emergency ation so she sent her out.		"Notification of changes, Notific MD/NP and RP. When alerted change in a resident, complete assessment and document. R changes include bruises of unlorigin"	d of a e an deporting		
	An interview was cor RP on 05/29/18 at 2: arrived at the facility 10:15 AM to take Re and was waiting on t The RP stated Visito her of what she had with Resident #1. Th #3 pushed Resident saw her for the first t mouth was drawn to she asked Resident stated she was not o asked Nurse #3 if Re looked like she had a	nducted with Resident #1's 17 PM who stated that she on 05/12/18 at approximately sident #1 out for a few hours he staff to get her dressed. If #1 came in and informed witnessed the day before he RP stated that when Nurse #1 into the dining area she hime that day and noticed her her right side. The RP stated #1 if she was okay and she kay. The RP stated she then her sident #1 was okay that she he a stroke and Nurse #3 told have that was that morning. The RP		On 5/30/18, the facility administ DON consulted with the region president (RVP) and corporate consultant. The RVP and corporate consultant re-educated the administration of topics of Quality of Care and the requirements for Notification of In addition, the RVP and corporate consultant reviewed with the alignment of the RVP and corporate consultant reviewed with the alignment of condition policy, 3) failure to a change of condition resulting for the follow established policy, an importance of addressing residuance concerns related to Quality of the RVP and corporate to a change of condition policy, an importance of addressing residuance of addressing residuance concerns related to Quality of the RVP and corporate to the RVP and corporate	al vice RN facility corate ministrator overed the ne f Changes. orate dministrator e in sssess for rom failure ad 4) the dent/family		

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F 580	Continued From pag	e 8	F 58	0			
F 580	stated she insisted R for evaluation and the that she was not notice in condition, having a started on an antibior informed of her having speech or drooling up to the ER. An interview was connected that on the more arrived at the facility Resident #1's RP was having a stroke. The immediately went to initially could not tell her until Resident #1 knew something was The DON also stated that on the morning of 05/11/18. #1's symptoms were then they should have well. On 05/30/18 at 12:10 conducted with the M stated that if Resider droop, drooling and sthat those were all cl should have been rethe building so the retimmediately and sen The MD continued to	desident #1 be sent to the ER bey did. The RP explained fied of Resident #1's change a UTI or that she had been to not had she been ag facial droop, slurred intil the morning she was sent and ucted with the Director on 6/30/18 at 3:30 PM who orning of 05/12/18 she had and was informed that as there and felt that she was DON stated she check on Resident #1 but if anything was wrong with tried to speak then she anot right with Resident #1. If she was not aware that having facial droop and evaluated her on the The DON added if Resident reported to the nursing staffine been reported to her as a dedical Doctor (MD) who in the tried to the NP who was in the sident could be reevaluated to the emergency room. In the state that Resident #1 had in the sident #1 had the state that Resident #1 had in the sident #1 had in the sid	F 58	On 5/30/18, the corporate consinitiated a 100% audit of the nuprogress notes from 5/1/18 thro 5/30/18. The purpose of the audentify any needed resident as for Resident #1 or other resider a change of condition that has assessed and addressed throu physician/NP provider notification totification. Any resident need assessment will be assessed be notifications made to the care pand RR. 6/21/18 the Facility RN consultare-educated the IDT (Interdiscipated) Team) on the morning clinical metrogress notes dated from previous in morning clinical meeting progress notes dated from previous in reside conditions to include notification physician and or Physician Extended Representative. The include copies of physician ordialerts that include meal intake, incidents, care plan updates or and resident and or family condition by end of day. The the daily IDT team meeting will communicated to the Administr	arse bugh budit was to besessment int at risk of not been gh on and RR ing by a RN and brovider ant plinary neeting cess. by team) will ing the vious to ootential ent n of ender and review will ers, clinical skin alerts, revisions, berns. The document eresults of be ator.		
	The MD continued to returned to her basel	state that Resident #1 had ine neurologically and one well while working with		-	ator. Its of the e will be		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345562	B. WING_				C 5/31/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227			5/3 1/2010
(X4) ID PREFIX TAG			(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 580	presented to the ER. abnormal and indica determine how old. I we could not identify how old it was along age she would not he treatment of tissue p (treatment for stroke Review of the Dischar hospital dated 05/16 had presented to the scan of her head revindeterminate lunar (ganglia and right that Her readmitting diag stroke. An observation was 05/30/18 at 12:10 Pher wheelchair in the calm and no facial diagram and the calm and no facial diagram and pfacial droop was eviced on 05/30/18 at 4:51 notified of Immediate provided the following removal on 05/31/18 1. The plan of controls and the could be controls and indicated the plan of controls and indicated the plan of controls and indicated the plan of controls.	the scan of her brain was ted a stroke but could not The MD added that because when the stroke occurred or with Resident #1's advanced ave qualified for the lasminogen activator (TPA). The MD added that because when the stroke occurred or with Resident #1's advanced ave qualified for the lasminogen activator (TPA). The arge Summary from the plant indicated Resident #1 and the realed punctate age plant in the right basal lamus (parts of the brain). The arge Summary from the prealed punctate age plant in the right basal lamus (parts of the brain). The arge Summary from the prealed punctate age plant in the realed punctate age plant in the right basal lamus (parts of the brain). The arge Summary from the prealed punctate age plant in the realed of Resident #1 on the plant in the reside	F	580	monthly for three months then quarter for review and guidance. If additional issues are noted those iss will be addressed immediately and corrective action taken 4. The title of the person responsible implementing the acceptable plan of correction. The administrator will be implementing and is responsible for implementing the acceptable plan of correction.	ues	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
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F 580	Jeopardy at 5:00 PM of Care. The process was determined to be the family/physician/#1's change of condishowed signs of facial 2. The procedure acceptable plan of codeficiency cited On 5/10/18, the MDS Note indicated Resided in ot indicate Resided in ot indicate Reside or other change in comparison of the comparison	r was placed into Immediate for failing to provide Quality to that led to the deficiency to the facility's failure to notify nurse practitioner of Resident tion when the resident all drooping and drooling. For implementing the precision of the specific	F	580				
		ed Resident #1's speech						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	,	
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F 580	resident to Nurse #1 On 5/11/18, at approrestorative aide with Resident #1 and wat Resident #1 to the n Nurse #1 did not doc electronic health recowas a change of con a registered nurse (For physician (MD) to afternoon as the day On 5/11/18 at approxesident's family merattempted to approach Resident #1. Nurse recall this specific viston Nurse #1 that Resistouched posture, dr Nurse #1 stated the the morning and Resident #1. At that time, Nurse #1 at that time, Nurse #1. At that time, Nurse #1 at that	eximately 1:00 PM, the essed Nurse #1 looking at ched Nurse #1 transport urse station for observation. Eximately 2:45 PM, a different expressed on 5/11/18. Eximately 2:45 PM, a different expressed expressed on 5/11/18. Eximately 2:45 PM, a different expressed ex	F 58	30		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 580	Continued From pag	ge 12	F 58	80		
	The assessment revelopment of the contacted Resident practitioner provider to send Resident #1 department (ED) for contacted Resident (RR)/daughter. RN ED as ordered by the Resident #1 at the Erepresentative/daughtat Resident #1 waresident representation of the contacted Resident #1 waresident representation of the contacted Resident #1 waresident representation of the contacted Resident #1 because of CVA, DNR, demedications ordered	N) #1 assessed Resident #1. realed Resident #1 had a (right facial drooping). RN #1 #1's physician/nurse . The provider gave an order to the emergency evaluation. RN #1 also #1's resident representative #1 sent Resident #1 to the e provider. The RR met ED. The resident hter reported to ED physician s at baseline on 5/10/18. The ive/daughter also reported drooping on the morning of 5/16/18, the ED physician g laboratory and radiology test evidence that Resident #1 lar (CVA), "Workup here so except the fact that she has was also started on antibiotics infections yesterday." On rders were given to discharge the facility with no d. The discharge diagnoses ntia, hyperlipidemia, and				
	summary. Resolved cystitis without hem: #1 returned to the fainstruction for hospida. The monitoring plan of correction is					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED		
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F 580	On 5/30/18, the min wound nurse RN as RN assessment of e vital signs, pain, and	regulatory requirements imum data set (MDS) RN and sessed each resident. The each resident included taking I mental status for change in	F 5	580			
	to protect Resident a similar situations. The assessments: no cunew/previously unider requiring additional a	urrent facility residents have a entified change in condition					
	a re-education with a nursing assistants (I The re-education co "Notification." "Notification of chan and RP. When alert complete an assess	ctor of nursing (DON) initiated all nursing staff to include NAs), MAs, LPNs, and RNs. vered the topic of ges, Notification of MD/NP and of a change in a resident, ment and document.					
	consulted with the re and corporate RN fa and corporate consu- administrator and Do covered the topics of requirements for No addition, the RVP ar reviewed with the act of: 1) Change in Co- assess for change of failure to follow esta	ity administrator and DON egional vice president (RVP) cility consultant. The RVP ultant re-educated the ON. The re-education f Quality of Care and the tification of Changes. In and corporate consultant dministrator and DON topics ndition policy, 3) failure to f condition resulting from blished policy, and 4) the ssing resident/family					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227		13/3 1/20 16
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 580	concerns related to COOn 5/30/18, the corporation of the nurse of 100% audit of the nurse of 100% audit of the nurse of 100% audit of the nurse of 100% and 100% assessment and 100% an		F 5	80		
F 684 SS=J	implementing the acc The administrator will responsible for impler of correction. Immediate Jeopardy 5:53 PM when intervi revealed they had be report a resident's ch who to report the cha Quality of Care CFR(s): 483.25 § 483.25 Quality of ca Quality of care is a fu applies to all treatment facility residents. Bas assessment of a residents received accordance with professions.	teptable plan of correction. The implementing and is menting the acceptable plan was removed on 05/31/18 at the ews with nursing staff en educated on when to ange in condition as well as the implemental principle that the theorem and the comprehensive dent, the facility must ensure the treatment and care in the essional standards of the essional standards of the implemental is mention.	F 6	84		6/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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TO WILL OF T	NOVIBER OR COLL FIER				0506 CLEAR CREEK COMMERCE DRIVE		
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	<u> </u>			IV	I		
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F 684	Continued From p	age 15	F	684			
	-	ENT is not met as evidenced	' '	704			
	by:	in is not met as evidenced					
	•	ations, record reviews, staff,			F684 Quality of Care		
		se Practitioner, and Medical			1 00 1 Quality of Guid		
	Doctor interviews						
	resident that exhib			1. The plan of correcting the specific			
	cerebrovascular accident (stroke). This resulted				deficiency. The plan should address th	ıe	
	in a delayed hospi			processes that led to the deficiency cit	ed		
	treatment for a stre	oke 1 of 3 residents sampled					
	for quality of care	(Resident #1).			On 5/30/18, Clear Creek Nursing and		
					Rehabilitation Center was placed into		
		dy began on 05/11/18 when			Immediate Jeopardy at 5:00 PM for fai	•	
	Resident #1 begar			to provide quality of care. The process			
		cluded slurred speech, right			that lead to the deficiency was determined to be the facility's failure to access for	nea	
		and drooling. Nurse #1 was staff and visitors that Resident			to be the facility's failure to assess for change of condition when the licensed		
	· -	slurred speech, right sided			practical nurse (LPN, Nurse #1) did no		
	_	drooling and did not assess			report to a registered nurse (RN) for	•	
		ediate jeopardy was removed			re-assessment of Resident #1 after		
		3 PM when the facility provided			receiving reports of the resident showi	ng	
		an acceptable allegation of			signs of facial drooping and drooling.	Ü	
	immediate jeopard	ly removal. The facility remains					
	out of compliance	at a lower scope and severity			2. The procedure for implementing the)	
		arm with potential for more			acceptable plan of correction for the		
		that is not immediate			specific deficiency cited		
		lete education and ensure					
		s put into place for assessing a			On 5/10/18, the minimum data set (MD)S)	
	resident with a cha	ange in condition are effective.			nurse's care plan – General Note		
	The findings include	dod:			indicated Resident #1 was at baseline did not indicate Resident #1 with facial		
	The infairigs includ	iea.			drooping or other change in condition.		
	Resident #1 was a	admitted to the facility on			are oping or other change in condition.		
		noses that included dementia			On 5/11/18 earlier in the day before 11		
	and hypertension.				AM, Nurse #1 did observe Resident #1		
		st recent comprehensive			change in clarity of speech, but did not		
		t (MDS) dated 02/23/18			see any facial drooping or drooling, an		
		dent #1 was cognitively			then called the nurse practitioner to ve		
	impaired and requ	ired limited assistance with			the nurse practitioner would be at the		
	activities of daily li	ving The MDS further revealed			facility on 5/11/18 Nurse #1 is a LPN a	and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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ind		,			DEFICIENCY)		
Г 604	0	- 40					
F 684	Continued From page		F 6				
	that Resident #1 had usually understood b	clear speech and was y others.		- 1	is not in the scope of practice for an PN to assess.		
		ractitioner (NP) progress			n 5/11/18 at approximately 11:46 AM		
		3 at 11:46 AM read, Resident		- 1	ne physician extender nurse practition		
	#1 was seen for acut				NP) note indicated Resident #1 was s	een	
		d notes were reviewed. Staff			y the NP. The NP note indicated		
		#1 has had change in mental			Patient seen for acute care. Meds, la		
	status and was having difficulty speaking. Resident #1 was very confused and was not			- 1	otes reviewedalert, confusedUA		
					eviewed, + for leukocytes, positive for		
	interacting with me w				itratespatient refuses PO medication		
	assessment revealed Resident #1 was calm and			-	ive Rocephin 1 gram IM q24h x 3 do:		
	pleasant but confuse	d. Review of a urinalysis		gi	ive with lidocaine." The NP note did	not	
	(analysis of the urine) revealed it was positive for		in	dicate Resident #1 with right facial		
		t could indicate a urinary		dı	rooping.		
	tract infection) and ni	trites (a cell that could					
	indicate a urinary trad	ct infection). The		0	n 5/11/18 at approximately 1:00 PM,	the	
	assessment and plan	read, Urinary tract infection		re	estorative aide noticed Resident #1's		
	(UTI): Resident #1 re	fuses to take medications by		s	peech was not clear while weighing h	ier	
	mouth. Give Rocephi	in (antibiotic) 1 gram (gm)		aı	nd took the resident to Nurse #1.		
	intramuscular (IM) ev	very day for 3 days.					
				0	n 5/11/18, at approximately 1:00 PM	, the	
	An interview was con	iducted with the NP on		re	estorative aide witnessed Nurse #1		
	05/29/18 at 4:34 PM.	The NP stated that on		lo	oking at Resident #1 and watched		
	05/11/18 Nurse #1 st	ated "something was wrong"		N	urse #1 transport Resident #1 to the		
	with Resident #1. The	e NP stated she went to see		n	urse station for observation. Nurse #	1	
		luated her and reviewed her		- 1	id not document her observation of		
	laboratory values. Th	e laboratory values indicated		R	esident #1 in the electronic health		
	that she had a UTI ar	nd she was not her usual		re	ecord. Not recognizing there was a		
		The NP stated at the time			hange of condition, LPN #1 did not n	otify	
		ent #1 she had no slurred			registered nurse (RN), NP, or physic	-	
		signs that indicated she may			MD) to re-assess Resident #1 in the		
		troke or she would have sent			fternoon as the day progressed on		
		ospital. She indicated that her		- 1	/11/18.		
		ew of her medical record		"			
		ent #1 had a UTI and she		0	on 5/11/18 at approximately 2:45 PM,	а	
		ohin for 3 days. The NP also			ifferent resident's family member	_	
		as not alerted to any other			eported that she attempted to approa	ch	
		red with Resident #1 that			urse #1 regarding Resident #1. Nurs		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 684	Continued From page	e 17	F 68	4			
	day.			#1 stated she could not recall th visitor interaction.	is specific		
	Aide (RA) on 05/29/1 stated that on 05/11/the facility. While wei approximately 1:00 F Resident #1 was not agitated her speech RA indicated that she wheelchair to Nurse speech was slurred a herself. She stated N was aware of Reside Resident #1 back tow An interview was con 05/29/18 at 3:40 PM. arrived at the facility 2:45 PM and noticed the halls hollering but	I'M the RA noted that acting like herself, she was was slurred and muffled. The pushed Resident #1 in her #1 and informed her that her and she was not acting like urse #1 indicated that she not #1's condition and pushed wards her room. Iducted with Visitor #1 on Visitor #1 indicated she on 05/11/18 at approximately Resident #1 rolling around to nothing she said made any dicated that Resident #1 was		On 5/11/18 after 5:00 PM, the threported to Nurse #1 that Reside was exhibiting slouched posture and slurred speech. Nurse #1 s NP assessed the resident in the and Resident #1 was on antibiot for a urinary tract infection. On 5/11/18 at approximately 6:0 Nurse #1 administered an antibininjection for Resident #1. At that Nurse #1 did not note observing drooping or drooling. On 5/11/18 at the 7 PM shift chat Nurse #1 reported to medication (MA) #1. Nurse #1 and MA #1 or report to a RN Resident #1's chat condition (right facial drooping, and continued slurred speech) for assessment, failing to follow estates.	ent #1 , drooling tated the morning cic therapy 0 PM, otic t time, facial ange, a aide did not lange in drooling, or		
	drooling and her mouth was drawn to one side but she could not recall which side. Visitor #1 stated she saw Nurse #1 and stated to her "I think Resident #1 is having a stroke." Visitor #1 stated that Nurse #1 replied "we are taking care of it" and that was it. Visitor #1 stated that later in the day she told Visitor #2 that something was wrong with Resident #1. Visitor #1 stated she did not see Nurse #1 go and check on Resident #1 during her time in the facility. An interview was conducted with Visitor #2 on 05/29/18 at 4:10 PM. Visitor #2 stated that she arrived at the facility on 05/11/18 at approximately 5:00 PM and was informed by Visitor #1 that something was wrong with Resident #1. Visitor #2			policy. On 5/12/18 at approximately 10: RN #1 assessed Resident #1. T assessment revealed Resident # change in condition (right facial of the change in condition) RN #1 contacted Resident #1's physician/nurse practitioner provider gave an order to send for the emergency department evaluation. RN #1 also contacted Resident #1's resident represent (RR)/daughter. RN #1 sent Resident #1 sent Resident #1 at the ED. resident representative/daughter.	The #1 had a drooping). vider. The Resident t (ED) for ed tative iident #1 vider. The The		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 684	Continued From page 18			1		
	wheelchair and was but her speech was Visitor #2 stated she help Resident #1 ar	erved Resident #1 in her making all kinds of noises slurred and she couldn't talk. e went to look for someone to a found Physical Therapist asked them to check on		to the ED physician that Resident #15 at baseline on 5/10/18. The resident representative/daughter also reported noticing right facial drooping on the morning of 5/12/18. On 5/12/18 through 5/16/18, the ED		
	#2 on 05/29/18 at 5 05/11/18 at approximate to the therapy Resident #1 had sludroop and was droograbbed PT #2 and Resident #1 and "for symptoms described that they went to Nu Resident #1's condition and she hearlier that day and PT #2 stated she acconcern with Resident Wurse #1 stated she PT #2 did not see Nand after they inform	anducted with PT #1 and PT :30 PM. PT #1 stated that on mately 5:30 PM Visitor #2 or gym and stated that urred speech, she had facial bling. PT #1 indicated that she they went to check on mund her to exhibit the same d" by Visitor #2. PT #1 stated urse #1 to inform her of tion. PT #1 stated that Nurse was aware of Resident #1's ad been seen by the NP was being treated for a UTI. gain informed Nurse #1 of her ent #1's facial droop and again e was aware. Both PT #1 and lurse #1 assess Resident #1 med Nurse #1 of their ned to the therapy gym to		physician evaluation, including labora and radiology test results indicated no evidence that Resident #1 had a cerebrovascular (CVA), "Workup here far has been normal except the fact the she has been hypertensive, was also started on antibiotics for her urinary transfections yesterday." On 5/12/18, physician orders were given to dischar Resident #1 back to the facility with norm medications ordered. The discharge diagnoses of CVA, do not resuscitate (DNR), dementia, hyperlipidemia, and hypertension are listed on the hospital discharge summary. Resolved diagnoses of CVA, Resident #1 returned to the facility with discharge instruction for hospice evaluation.	e so nat act arge o	
	An interview was co 05/29/18 at 5:20 PM 05/11/18 in report s needed to evaluate was not acting like I she did not see or in morning because sl and Resident #1 was			3. The monitoring procedure to ensure that the plan of correction is effective that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements On 5/30/18, the MDS RN and wound nurse RN assessed each resident. The RN assessment of each resident inclutaking vital signs, pain, and mental states.	and ne he uded	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSIDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BOILDI	_		Ι ,	С
		345562	B. WING _			1	31/2018
NAME OF PI	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	01/2010
				10	0506 CLEAR CREEK COMMERCE DRIVE		
CLEAR CI	REEK NURSING & REH	IABILITATION CENTER		M	IINT HILL, NC 28227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCE TO THE APPROPRIA		(X5) COMPLETION DATE
					DEFICIENCY)		
F 684	Continued From pag	ge 19	F	684			
	the RA brought Res	ident #1 to me stated that she			for change in condition. The purpose of	of	
	was not acting like h	nerself and her speech was			the assessment was to protect Resider	nt	
	slurred. Nurse #1 in	dicated she was aware of her			#1 and other residents in similar		
		that the NP had seen her and			situations. The findings of the		
	ordered her an antib	piotic for a UTI. Nurse #1			assessments: no current facility reside	nts	
		n the day two PTs had come			have a new/previously unidentified cha	nge	
		ident #1 was not acting like			in condition requiring additional		
		nibiting slurred speech, facial			assessment or physician/NP notification	n.	
		. Nurse #1 stated that she					
	·	d #2 that she had already			On 5/30/18, the director of nursing (DC	·N)	
	been assessed and she was being taken care of.				initiated a re-education with all nursing		
		t she did not think she needed			staff to include nursing assistants (NAs	-	
	•	esident #1 because the NP			MAs, LPNs, and RNs. The re-education	tion	
	nad aiready assesse	ed her earlier in the day.			covered the topic of "Notification."		
	A f-11				"Notification of changes, Notification of		
	•	v was conducted with Nurse			MD/NP and RP. When alerted of a		
		0:26 AM. Nurse #1 confirmed			change in a resident, complete an		
	_	not assessed Resident #1 for on and did not ask any other			assessment and document. Reporting changes include bruises of unknown		
	_	sident #1. She acknowledged			origin"		
		#1, PT #1 and #2 had			origin		
		erns to her about Resident			On 5/30/18, the facility administrator ar	nd	
		, facial droop, and drooling			DON consulted with the regional vice	10	
		at they were all effects from			president (RVP) and corporate RN faci	litv	
		stated that after the RA			consultant. The RVP and corporate		
		1 to her earlier that day she			consultant re-educated the administrat	or	
	_	nt #1 again until 6:00 PM when			and DON. The re-education covered the		
		ster her ordered antibiotic			topics of Quality of Care and the		
	injection and at that	time she did not notice any			requirements for Notification of Change	es.	
	change to her condi				In addition, the RVP and corporate		
	_				consultant reviewed with the administra	ator	
	An interview was co	onducted with Nursing			and DON topics of: 1) Change in		
	Assistant (NA) #1 or	n 05/30/18 at 12:54 PM. NA			Condition policy, 3) failure to assess fo		
	#1 confirmed that sh	ne took care of Resident #1			change of condition resulting from failu	re	
	on 05/11/18 on 1st a	and 2nd shift. She stated that			to follow established policy, and 4) the		
	Resident #1 was no	t acting like herself and her			importance of addressing resident/fam	ly	
	speech was slurred			concerns related to quality of care.			
	one side of her mou	ith. NA #1 stated that she					
	alerted Nurse #1 an	d was told that Resident #1			On 5/30/18, the corporate facility		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X	(X3) DATE SURVEY COMPLETED	
						С	
		345562	B. WING _			05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
				10506 CLEAR CREEK COMMERCE DI	RIVE		
CLEAR C	REEK NURSING & RE	HABILITATION CENTER		MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 684	Continued From page 20		F 6	84			
F 684	had already been of being treated for a placed Resident # routine and when s 05/11/18, Resident eyes closed. An interview was c 05/30/18 at 11:54 worked 3rd shift or Resident #1 rested she did not notice #2 stated that she Resident #1 at app 05/12/18 but during notice any usual be normal with Reside would have noticed would have alerted. An interview was c 05/31/18 at 12:50 I he was working 3rd responsible for Resident #1 at 12:50 I he was working 3rd responsible for Resident #1 the UTI. Nurse #2 state throughout the night with Resident #1 the did not report any cand it was a normal and it was a normal with resident #1 the did not report any cand it was a normal and it was a	evaluated by the NP and was UTI. NA #1 stated that she in the bed per her usual she left her shift at 11:00 PM on with the was resting in bed with her onducted with NA #2 on AM. NA #2 confirmed that she in 05/11/18 and stated that in bed the entire night and anything different with her. NA rendered incontinent care to proximately 5:00 AM on go that interaction she did not enavior or anything out of the entire in the interaction she in the nurse. Onducted with Nurse #2 on PM. Nurse #2 confirmed that it is she if any abnormal behavior she in the nurse. Onducted with Nurse #2 on PM. Nurse #2 confirmed that it is shift on 05/11/18 and was sident #1. Nurse #2 stated that it is notified that Resident #1 go like herself but had been P and was on antibiotic for each that Resident #1 rested that night. He added that NA #2 unusual behavior that evening all night for Resident #1.	F 6	consultant initiated a 100% in nurse progress notes from 5/30/18. The purpose of the identify any needed resident for Resident #1 or other resident a change of condition that he assessed and addressed the physician/NP provider notification. Any resident notification. Any resident notifications made to the calcand RR. On 6/22/18, the corporate factor consultant re-educated the Interdisciplinary Team (IDT) but not limited to the DON, 50 Development Coordinator (50 treatment nurse, MDS Nurse manager, activity director, representative and social semorning clinical meeting form follow up items process. New members will receive training morning clinical meeting during the SDC. The nurse that is assigned the is responsible for the assess resident when a change of content of the change of the ch	5/1/18 through a audit was to tassessment ident at risk of as not been rough cation and Receding and by a RN and re provider acility - that includes Staff SDC), e, unit rehab ervices - on the mat, and wly hired IDT g on the ring orientation of the condition has e occurs not on duty — A will call the tinent data.	f R d d s e e n t	
	she worked 05/12/ responsible for Rea approximately 10:0	M. Nurse #3 confirmed that 18 on 1st shift and was sident #1. Nurse #3 stated that 00 AM Resident #1's family and asked that Resident #1's		The on-call RN will then be for completing the assessment resident. On 6/25/18, the DON began	ent of the	e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI	_		1 ,	C	
		345562	B. WING				31/2018	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	31/2016	
TO AVIL OF TH	to vibert of tool i eleft				0506 CLEAR CREEK COMMERCE DRIVE			
CLEAR C	REEK NURSING & REHA	ABILITATION CENTER			IINT HILL, NC 28227			
				IV	 			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 21	F	684				
	vital signs be checke				the MAs, LPNs, and RNs on the proces	38		
		h her. Nurse #3 stated that			for assessment and change of condition			
		sident #1 prior to the family			and notification to the physician, physic			
		ck Resident #1's vital sings.			extender and resident representative.			
		when she went to obtain			Newly hired nurses and medications ai	des		
		gns she did not notice any			will receive the education on the			
	_	op. She stated that she			assessment and change of condition a	nd		
	_	smile and she did and she			notification during their orientation perio			
		lift both her arms in the air			3			
	and she was able to	do that. Nurse #3 stated that			The facility IDT will review in morning			
	her assessment reve	aled no change in Resident			clinical meeting the progress notes dat	ed		
	#1 from her baseline	but the family requested that			from previous to current meeting to			
	Resident #1 be sent t	to the Emergency Room			determine potential changes of condition	ons		
	(ER) for evaluation a	nd so she sent her out.			in resident conditions to include			
					notification of physician and or Physicia	an		
	An interview was con	ducted with Resident #1's			Extender and Resident Representative			
	family on 05/29/18 at	2:17 PM. The family			The review will include copies of physic	cian		
	member stated that s	the had visited Resident #1			orders, clinical alerts that include meal			
		nd her to be in her usual			intake, skin alerts, incidents, care plan			
		amily member stated that			updates or revisions, and resident and			
	she came to the facili				family concerns. The DON will docume	nt		
		AM and was sitting in the			any follow up items that require			
		on the staff to get her family			completion by end of day. The results	of		
		e added that Visitor #1 came			the daily IDT team meeting will be			
	l	amily member of what she			communicated to the administrator.			
		/11/18 with Resident #1. The			T	_		
	family member stated				To maintain continued the results of the			
	·	ember into the dining room			follow-up items and compliance will be			
		r for the first time that day			submitted to the facility's QAPI (quality			
	-	her mouth was drawn to the			assurance/performance improvement) Committee monthly for three months th	on		
	_	ated she asked Resident #1 Resident #1 stated "no I am			quarterly for review and guidance. If	CII		
	_	t1's family member stated to			additional issues are noted those issue	e		
	-	ly member ok she looks like			will be addressed immediately and	3		
	_	" and Nurse #3 replied "she			corrective action taken.			
		norning." Resident #1 stated			Consolive delien taken.			
		#3 she wanted her family						
		he ER for evaluation and			4. The title of the person responsible for	or		
	they did.				implementing the acceptable plan of			

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
			A. BOILDIN			c	
		345562	B. WING _			5/31/2018	
NAME OF PI	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP		0/01/2010	
				10506 CLEAR CREEK COMMERCE	DRIVE		
CLEAR CI	REEK NURSING & REH	ABILITATION CENTER		MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	o5/31/18 at 1:24 PM. was working on 05/1 stated that Resident and look at Resident instant she saw her start to the right side someone who had a she summoned the Ecome and look at Resent to the ER for ev. An interview was cor 05/30/18 at 3:30 PM. morning of 05/12/18 NA #3 informed her to member was in the fa #1 was having a stroimmediately proceed Resident #1 and initinot tell anything was started to speak she right. The DON state was very slurred and were on the way. She that they were on the Resident #1 was trare evaluation. The DON that on 05/11/18 some evaluated by the NP droop and drooling a reported to the nursin contacted her.	nducted with NA #3 on . NA #3 confirmed that she 2/18 on 1st shift. NA #3 #1's family asked her to go #1. NA #3 stated that the she noticed her face was le and she looked like stroke. NA #3 stated that Director of Nursing (DON) to sident #1 and she had her	F 6	correction. The administrator will be i and is responsible for impacceptable plan of correct	lementing the		
	stated that if Resider	0/18 at 12:10 PM. The MD nt #1 began to display facial slurred speech those were					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION IG	, ,	(X3) DATE SURVEY COMPLETED	
		345562	B. WING_			C 05/31/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	I	03/31/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	these symptoms wer staff on 05/11/18 the should have been module have been ree immediately out to the Resident #1 had retuneurologically and play while working with the Resident #1 presents brain was abnormal could not determine because we could not occurred or how old #1's advanced ages for the treatment of to (TPA) (treatment for Review of the discharbonate has all ganglia and right brain). Her readmitting included CVA (stroked An observation was 05/30/18 at 12:10 PM her wheelchair in the calm and no facial did An observation was 05/31/18 at 8:00 AM the breakfast table was could have been made to the staff of the staff	stroke. The MD stated that if the reported to the nursing NP who was in the building ade aware so Resident #1 valuated and sent the ER. The MD stated that the stroke in the ER her by sically and had done well erapy. He added that when the early had been the erapy. He added that when the erapy. He added that when the erapy had been the erapy. He added that when the erapy had been the would. The MD added that the erapy when the stroke it was along with Resident the would not have qualified issue plasminogen activator stroke). In the erapy had been the erapy h	F 6	84		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345562	B. WING _			C 05/31/2018
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIV MINT HILL, NC 28227		30/01/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	The plan should add to the deficiency cite On 5/30/18, Clear	recting the specific deficiency. Itress the processes that led and reek Nursing and are was placed into Immediate If for failing to provide Quality is that lead to the deficiency is the facility 's failure to if condition when the licensed If Nurse #1) did not report to if Nurse #1) did not report to if condition when the resident if ald drooping and drooling. and the resident 's change in ed the nurse practitioner ent 's needs by performing prescribing an antibiotic for ary tract infection. for implementing the orrection for the specific S nurse's Care Plan - General dent #1 was at baseline and	F	584		
	or other change in of On 5/11/18, earlier in Nurse #1 did observed clarity of speech and drooping or drooling the nurse practitioned practical nurse (LPN)	ident #1 with facial drooping ondition. In the day before 11 AM, the Resident #1's change in the did not see any facial earlier in the day and did call the earlier in the see the cope of to assess. Not recognizing				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345562	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	05/31/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684	there was a change of notify a registered nut (NP), or physician (Min the afternoon as the 5/11/18. On 5/11/18 at approximate Physician Extender in indicated Resident #1 NP note indicated "Physician Extender indicated Resident #2 NP note indicated "Physician Extender in indicated Resident #3 NP note indicated "Physician Extender indicated "Physician Extender "Physician Extender Indicated "Physician Indicated Indicated "Physician Indicated Indicated "Physician Indicated	of condition, LPN #1 did not rse (RN), nurse practitioner D) to re-assess Resident #1 e day progressed on simately 11:46 AM, the urse practitioner (NP) note I was seen by the NP. The atient seen for acute care. Friewedalert, confused leukocytes, positive for ses PO medications, give q24h x 3 doses, give with ote did not indicate Resident proping. Simately 1:00 PM, the red Resident #1's speech reighing her and took the The restorative aide pooking at Resident #1 to the revation. Nurse #1 did not ment in the electronic health simately 2:45 PM, a different or reported that she she hurse #1 regarding #1 stated she could not itor interaction. PM, the therapist reported dent #1 was exhibiting pooling and slurred speech. NP assessed the resident in ident #1 was on antibiotic tract infection. imately 6:00 PM, Nurse #1 poiotic injection for Resident rese #1 did not note observing	F 684		

		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345562	B. WING_			C 05/31/2018	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	<u> </u>	03/31/2016	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 684	reported to medical and MA #1 did not (RN) Resident #1's facial drooping, dro speech) for assess established policy. On 5/12/18 at appropriete appropriete assessment rechange in condition contacted Resident practitioner provide to send Resident # department (ED) for contacted Resident (RR)/daughter. RNED as ordered by the Resident #1 at the representative/daughysician that Reside	PM shift change, Nurse #1 tion aide (MA) #1. Nurse #1 report to a registered nurse change in condition (right oling, and continued slurred ment, failing to follow eximately 10:08 AM, N) #1 assessed Resident #1. vealed Resident #1 had a a (right facial drooping). RN #1 a #1's physician/nurse r. The provider gave an order 1 to the emergency r evaluation. RN #1 also a #1's resident representative a #1's resident representative a #1 sent Resident #1 to the a provider. The RR met a ED. The resident b ghter reported to the ED dent #1 was at baseline on a right facial drooping on the	F 6				
	far has been normal been hypertensive, for her urinary tract 5/12/18, physician of Resident #1 back to medications ordered of CVA, DNR, demonstration are list summary. Resolve cystitis without hem	ular (CVA), "Workup here so al except the fact that she has was also started on antibiotics infections yesterday." On orders were given to discharge to the facility with no d. The discharge diagnoses centia, hyperlipidemia, and sted on the hospital discharge diagnosis included acute naturia. On 5/16/18, Resident acility with discharge					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED			
		345562	B. WING _	G		C 05/31/201	C 05/31/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER			RESS, CITY, STATE, ZIP CODE R CREEK COMMERCE DRIVE NC 28227	03/31/201	10	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPI	(5) LETION ATE	
F 684	plan of correction is deficiency cited remains		Fé	584				
	wound nurse RN ass RN assessment of e vital signs, pain, and condition. The purport to protect Resident similar situations. The assessments: no cunew/previously unider requiring additional anotification. On 5/30/18, the direct a re-education with anursing assistants (No The re-education con "Notification." "Notification of change and RP. When alert complete an assessing Reporting changes in origin" On 5/30/18, the facilic consulted with the reand corporate RN far and corporate consulted with the reand corporate consulted with the read addition, the RVP and reviewed with the addition, the RVP and reviewed with the addition.	entified change in condition assessment or physician/NP etor of nursing (DON) initiated all nursing staff to include NAS), MAS, LPNs, and RNs. evered the topic of ges, Notification of MD/NP ed of a change in a resident,						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345562	B. WING		C 05/24/2048
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	05/31/2018
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684	failure to follow establimportance of address concerns related to CO On 5/30/18, the corporation of the number of the stable of the number of the stable of	condition resulting from lished policy, and 4) the sing resident/family	F 684	4	
F 770 SS=D	implementing the acc The administrator will responsible for impler of correction. Immediate jeopardy v 5:53 PM when intervirevealed that they ha conducting assessme condition was reporter included if the nurse v resident that the expet to a nurse that could Laboratory Services CFR(s): 483.50(a)(1) §483.50(a) Laborator §483.50(a)(1) The fact laboratory services to	ents when a change of ed. The education also was unable to assess the ectation was that they report assess the resident.	F 77		6/29/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		345562	B. WING			C 05/31/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	·	5/01/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 770	services, the services requirements for labor		F 77	70			
	by: Based on record rev facility failed to obtain which was ordered by	iews and staff interviews the a resident's urine sample the physician for a culture of 3 residents reviewed for Resident #1).		F 770 Laboratory Services The plan of correcting the spectofficiency. The plan should adoprocesses that led to the deficiency.	dress the		
		dmitted to the facility on ses which included dementia		The position of Clear Creek Nu Rehabilitation Center regarding process that led to the deficient determined to be the facility's fanotify the physician/nurse pract difficulty obtaining Resident #1' specimen to carry out the physicorder for urine culture and sense	the cy was ailure to titioner of s lab ician's		
	required limited assis	•		The facility obtained the specim 05/09/18 and the results were communicated to the Nurse Pra and appropriately addressed. The procedure for implementing acceptable plan of correction for specific deficiency cited An 100% audit was started 5/3	actitioner g the or the		
	05/29/18 revealed in incontinence related risk for a urinary tract will be free from a UT interventions of enco intake, providing peri	t1's Care Plan revised on part a focus of urinary to cognitive impairment, at tinfection (UTI). Resident #1 TI by utilizing the uraging adequate fluid care after each incontinent ng for and reporting signs		Director of Nursing (DON) of all order for the past 30 days to en laboratory samples were drawn and communicated to physiciar manner. The audit was compler revealed no further negative fin	I laboratory nsure n, received, n in a timely ted and idings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7 50.12510		С		
		345562	B. WING			1/2018	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
01 545 0	DEEK NUIDOING & DEUA	DU ITATION OFNITED		10506 CLEAR CREEK COMMERCE DRIVE			
CLEAR CI	REEK NURSING & REHA	ABILITATION CENTER		MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 770	Continued From page	e 30	F 77	0			
	and symptoms of UT			the plan of correction is effective a specific deficiency cited remains c and/or in compliance with the regu	orrected		
		t1's Physician's order dated by Nurse # 4 revealed an		requirements			
	order to obtain a urin sensitivity (C&S whic	e sample for culture and h is a test to identify the tic that will work best to		On 5/30/18, the director of nursing initiated a re-education with all nur staff to include nursing assistants MAs, LPNs, and RNs. The re-edu covered the topic of "Notification."	rsing (NAs),		
	Nurse # 4 and dated "urine put in fridge fo			"Notification of changes, Notification MD/NP and RP. When alerted of a change in a resident, complete an assessment and document. Report changes include bruises of unknown arigin."	rting		
	from 05/04/18 throug	t1's Progress notes dated h 05/09/18 revealed no other ning to the urine sample was		origin" On 5/30/18, the facility administrat DON consulted with the regional v president (RVP) and corporate RN consultant. The RVP and corpora	ice I facility		
	conducted with Nurse received the order for (on 05/04/18) she trie of her shift (7:00 PM) unsuccessful becaus cooperate. The Nurse	PM an interview was e #4 who stated when she resident #1's urine culture ed two times before the end to obtain the urine but was e Resident #1 would not e stated she reported it to at she was unsuccessful.		consultant. The RVF and corporal consultant re-educated the administration and DON. The re-education cover topics of Quality of Care and the requirements for Notification of Ch to include notification of physician physician extender if lab specimen not able to be obtained as ordered	strator red the anges and or is are		
	Also during the interv 05/09/18 she realized	riew, Nurse #4 stated that on d Resident #1's urine had not nurse aide brought it to her		6/22/18 the Facility RN consultant re-educated the IDT (Interdisciplin Team) on the morning clinical mee format, and follow up items proces	ary eting		
	Nurse #2 he stated th	PM during an interview with ney tried several times to e from Resident #1 during		The facility IDT (Interdisciplinary to review in morning clinical meeting progress notes dated from previou current meeting to determine poter	the is to		

` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345562	B. WING		C 05/31/2018	
NAME OF PR	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	73172010
				10506 CLEAR CREEK COMMERCE DRIVE		
CLEAR CF	REEK NURSING & REHA	BILITATION CENTER		MINT HILL, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 770	Continued From page the shift of 7:00 PM to	e 31 o 7:00 AM on 05/04/18 but	F 7	70 changes of conditions in resident		
	notify the Medical Dire	they were unable to obtain		conditions to include notification of physician and or Physician Extende Resident Representative. The revieinclude copies of physician orders including lab orders to include obta specimens and results, clinical aler	w will ning	
	Aide (NA) #3 was cor made several attempt specimen from Resid unsuccessful. The NA	ent #1 but she was A continued to state that on ally successful in obtaining		include meal intake, skin alerts, inc care plan updates or revisions, and resident and or family concerns. Th (Director of Nursing) will document follow up items that require comple end of day. The results of the daily team meeting follow up will be communicated to the Administrator	e DON any ion by IDT	
		Its of Resident #1's urine nad a urinary tract infection iotic for treatment.		To maintain continued the results of Follow up items and compliance with shared by the Administrator with the Facility's QA Committee monthly for months then quarterly for review and statement of the statement	l be e three	
	conducted on 05/31/1 the fact that Resident obtained after a few of	ector of Nurses (DON) was 8 at 5:45 PM. She revealed #1's urine could not be lays, did not concern her as the NP was not notified that btain it.		guidance. If additional issues are noted those will be addressed immediately and corrective action taken 2. The title of the person respons implementing the acceptable plants	issues ble for	
	12:10 PM he stated h Resident #1's urine for could not be obtained have been notified.	ith the MD on 05/30/18 at e wrote the order to obtain or a C&S and if the urine within a day then he should		correction. The Director of Nursing will be implementing and is responsible for implementing the acceptable plan correction.		
F 842 SS=D	Resident Records - Id CFR(s): 483.20(f)(5),		F 8	42		6/29/18
	§483.20(f)(5) Resider	nt-identifiable information.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED	
		345562	B. WING			C 05/31/2018	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227		05/31/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 842	(i) A facility may not resident-identifiable to the facility may resident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical resident facility may resident for the extent to do so. §483.70(i) Medical resident facility for the extent to do so. §483.70(i) Medical resident facility for the extent to do so. §483.70(i) Medical resident facility for the extent to do so. §483.70(i) Medical resident facility for the extent facility for the extent facility for records for the formation containt for the except where (ii) Required by Law; (iii) For the individual, for the except facility for public health facilities, judicial and law enforcement purporses, research	release information that is to the public. elease information that is on an agent only in contract under which the agent disclose the information the facility itself is permitted ecords. In a contract with accepted distance with accepted distance and practices, the facility all records on each resident elements. Here is an a contract with a confidential elements is a confidential element of the interesident elease is their resident elease is their resident elements. The permitted by applicable law; they want in compliance elease is the compliance elease ele	F8	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345562	B. WING	B. WING		C 05/31/2018	
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 0506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	1 03/	31/2010
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from th there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The me (i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review edeterminations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as retained to the control of the results of any and resident review edeterminations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as retained to the control of the results of any and resident review for the results of any and resident review for the results of the res	ility must safeguard medical rainst loss, destruction, or records must be retained required by State law; or e date of discharge when and in State law; or ars after a resident reaches alaw. dical record must containon to identify the resident; sident's assessments; we plan of care and services or preadmission screening evaluations and acted by the State; and other licensed so notes; and logy and other diagnostic equired under §483.50. To is not met as evidenced cord review and staff a failed to document as over 6-day period to obtain dered by the physician for 1 ent #1) reviewed for	F	842	F 842 Resident Records The plan of correcting the specific deficiency. The plan should address th processes that led to the deficiency cite. The position of Clear Creek Nursing ar Rehabilitation Center regarding the process that led to the deficiency was determined to be the facility's failure to document the difficulty obtaining Resid	ed	
	Resident #1 was adm 09/18/14 with diagnos	nitted to the facility on ses that included dementia			#1's lab specimen to carry out the physician's order for urine culture and		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		С	
		345562	B. WING		05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.0 20.0	
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CLEAR C	REEK NURSING & R	EHABILITATION CENTER		MINT HILL, NC 28227		
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F 842	Continued From p	page 34	F 842	2		
	and hypertension.			sensitivity.		
	Davison of the core	-tt		The facility obtained the specimen on		
		st recent comprehensive t (MDS) dated 02/23/18		05/09/18 and the results were communicated to the Nurse Practition	nr	
		t #1 was cognitively impaired,		and appropriately addressed.	51	
		and was usually understood by		and appropriately addressed.		
	-	further indicated Resident #1		The procedure for implementing the		
		aff assistance with most		acceptable plan of correction for the		
	1	iving and was frequently		specific deficiency cited		
	incontinent of both	n bladder and bowel.		An 100% audit was started 5/31/18 by		
				Director of Nursing (DON) of all labora	-	
	Davious of the phy	raisian ardera for Desident #1		orders and progress notes for the past		
		sician orders for Resident #1 dated 05/04/18 to obtain a		days to ensure laboratory samples we drawn, received, and communicated to		
		culture and sensitivity (test		physician in a timely manner. The aud		
		tify the germs that cause the		was completed and revealed no further		
	-	t kind of medication will work		negative findings.		
				The monitoring procedure to ensure the	at	
				the plan of correction is effective and t		
		se progress notes for the period		specific deficiency cited remains corre		
		05/09/18 revealed an entry		and/or in compliance with the regulato	ry	
		nich read, "urine put in fridge for urther review revealed no other		requirements		
		attempts to obtain a urine		On 5/30/18, the director of nursing (DO	ON)	
	sample.	attompte to obtain a unite		initiated a re-education with all nursing	· · · · · · · · · · · · · · · · · · ·	
	P -			staff to include nursing assistants (NA		
				MAs, LPNs, and RNs. The re-education		
	Review of the uring	e culture results for Resident		covered the topic of "Documentation" t	0	
		3 revealed she had a urinary		include documentation of inability to		
		required an antibiotic for		obtain lab specimens and notification of	ot	
	treatment.			the physician of inability to obtain.	nd	
				On 5/30/18, the facility administrator a DON consulted with the regional vice	liu	
	During an intervie	w on 05/31/18 at 12:17 PM		president (RVP) and corporate RN fac	ilitv	
		d she received an order on		consultant. The RVP and corporate	,	
		a urine sample for Resident #1		consultant re-educated the administra	or	
		pts before the end of her shift		and DON. The re-education covered to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345562	B. WING			C 05/31/2018	
	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODI 10506 CLEAR CREEK COMMERCE DRIV MINT HILL, NC 28227	E	30.0 1/2010	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 842	Resident #1 would confirmed she report attempts to obtain a during shift report it Resident #1's med During an interview Nurse #2 revealed obtain a urine sample from the shift 7:00 PM to unsuccessful. Nurse document the atter in Resident #1's med During an interview Nurse Aide (NA) #2 day she was informurine sample from making several unsuccessful in obtain successful in obtain Resident #1 on 05/2 During an interview Director of Nursing have notified the moof receiving the ordobtain a urine sample added she would helearly document in the sample from making several unsuccessful in obtain Resident #1 on 05/2	s unsuccessful because not cooperate. Nurse #4 orted the unsuccessful the urine sample to Nurse #2 out did not document it in ical record. You on 05/31/18 at 12:50 PM staff tried several times to ple from Resident #1 during of 7:00 AM on 05/04/18 but was se #2 confirmed he did not mpts to obtain a urine sample edical record. You on 05/31/18 at 1:24 PM 22 was unable to recall the exact ned by the Nurse to obtain a Resident #1 but did recall successful attempts over the NA #2 added she was finally ning the urine sample from 109/18. You on 05/31/18 at 5:45 PM the (DON) indicated staff should redical provider within 24 hours are when they were unable to ple for Resident #1. The DON have expected for staff to a Resident #1's medical record	F 84	topics of Quality of Care and to requirements for Notification of to include notification/ docume physician and or physician exspecimens are not able to be ordered. 6/22/18 the Facility RN consure-educated the IDT (Interdisciplinate) on the morning clinical format, and follow up items promoted in the facility IDT (Interdisciplinate) in morning clinical meet progress notes dated from precurrent meeting to determine changes of conditions in reside conditions to include notification physician and or Physician Expesident Representative. The include copies of physician or including lab orders to include specimens and results, clinication include meal intake, skin alert care plan updates or revisions resident and or family concern (Director of Nursing) will docut follow up items that require conditions to the Administration of the	of Changes entation of tender if lab obtained as ltant ciplinary meeting ocess. ary team) will eting the evious to potential ent on of ctender and e review will ders e obtaining al alerts that is, incidents, and ins. The DON ment any ompletion by e daily IDT oe trator.		
	added she would h clearly document in	ave expected for staff to n Resident #1's medical record d why the urine sample was		will share the results of the Fo	ollow up submitted to nonthly for or review and those issues		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345562	B. WING		C	
NAME OF D	ROVIDER OR SUPPLIER	040002		STREET ADDRESS, CITY, STATE, ZIP CODE	05/	31/2018
NAME OF FI	NOVIDER OR SUFFLIER			10506 CLEAR CREEK COMMERCE DRIVE		
CLEAR C	REEK NURSING & REHA	BILITATION CENTER		MINT HILL, NC 28227		
	OLIMANA DV. OT	ATEMENT OF REFIGIENOIS		PROVIDER'S PLAN OF CORRECTION		247
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE			BE	(X5) COMPLETION DATE	
		SC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE e for	

PRINTED: 07/02/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345562	B. WING _		R-C 05/31/2018	
	ROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	03/31/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION	
{F 000}	INITIAL COMMENTS	8	{F 00	00}		
	483.25 (F684) at J					
	Resident #1 began to fa stroke that incluside facial droop, an notified by various stroke that was exhibiting slufacial droop, and drock Resident #1. Immed on 05/31/18 at 5:53 and implemented an immediate jeopardy out of compliance at of a D (no actual har than minimal harm the jeopardy) to complet monitoring systems resident with a chance. An extended survey facility's follow-up surveys that it is a stroke that it is a survey facility's follow-up surveys that it is a stroke that it is a survey facility's follow-up surveys that it is a stroke that it is a survey facility's follow-up surveys that it is a survey facility's follow-up surveys that is a survey facility is a sur	re education and ensure put into place for assessing a ge in condition are effective. was conducted as part of the				
	A revisit was conduct 05/31/18 and the fact compliance.					
{F 684} SS=J	Quality of Care CFR(s): 483.25		{F 68	34}	6/29/18	
	applies to all treatme facility residents. Basessment of a res	care undamental principle that ent and care provided to sed on the comprehensive ident, the facility must ensure e treatment and care in				
ADODATODY	DIDECTOR'S OF PROVINER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	DE	TITI F	(X6) DATE	

Electronically Signed 06/22/2018

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						R-C		
		345562	B. WING	B. WING		05/31/2018		
NAME OF PI	ROVIDER OR SUPPLIER		-	ST	REET ADDRESS, CITY, STATE, ZIP CODE	,		
				10	506 CLEAR CREEK COMMERCE DRIVE			
CLEAR CREEK NURSING & REHABILITATION CENTER			MI	NT HILL, NC 28227				
(X4) ID PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	1	ID PROVIDER'S PLAN (PREFIX (EACH CORRECTIVE A			(X5) COMPLETION	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	<u></u>	DATE	
{F 684}	Continued From page	e 1	{F 6	84}				
	accordance with profe	essional standards of		-				
		nensive person-centered						
	care plan, and the res							
	I -	is not met as evidenced						
	•	ns, record reviews, staff,			Clear Creek Nursing and Rehab			
		Practitioner, and Medical			acknowledges receipt of the Statement			
		facility failed to assess a			Deficiencies and proposes this Plan of			
	resident that exhibited signs and symptoms of				Correction to the extent that the summ	•		
		dent (stroke). This resulted			of findings is factually correct and in or			
		evaluation and possible			to maintain compliance with applicable			
		1 of 3 residents sampled			rules and provisions of quality of care of	of		
	for quality of care (Re	esident #1).			residents. The Plan of Correction is			
	Immediate iconardy b	2000 02 0E/11/19 when			submitted as a written allegation of			
		pegan on 05/11/18 when			compliance. Clear Creek Nursing and			
		exhibit signs and symptoms led slurred speech, right			Rehab response to this Statement of Deficiencies does not denote agreeme	nt		
		I drooling. Nurse #1 was			with the Statement of Deficiencies nor	110		
		aff and visitors that Resident			does it constitute an admission that an	v		
	-	rred speech, right sided			deficiency is accurate. Further, Clear	y		
	_	oling and did not assess			Creek Nursing and Rehab reserves the	د		
		ate jeopardy was removed			right to refute any of the deficiencies of			
		PM when the facility provided			this Statement of Deficiencies through	•		
		acceptable allegation of			Informal Dispute Resolution, formal			
		emoval. The facility remains			appeal procedure and/or any other			
	l	a lower scope and severity			administrative or legal proceeding.			
		n with potential for more			3 P			
	than minimal harm th							
	jeopardy) to complete	e education and ensure						
		ut into place for assessing a			F684 Quality of Care			
	resident with a chang	e in condition are effective.						
					1. The plan of correcting the specific			
	The findings included	:			deficiency. The plan should address the processes that led to the deficiency cite			
	Resident #1 was adm	nitted to the facility on			ŕ			
		ses that included dementia			On 5/30/18, Clear Creek Nursing and			
	and hypertension.				Rehabilitation Center was placed into			
	Review of the most re	ecent comprehensive			Immediate Jeopardy at 5:00 PM for fail	ing		
	Minimum Data Set (N				to provide quality of care. The process	-		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345562 B. WING _			R-C 05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER	1.5552	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	05/31/2016	
	1011211 011 001 1 21211			10506 CLEAR CREEK COMMERCE DRIVE		
CLEAR C	REEK NURSING & REHA	ABILITATION CENTER	I	MINT HILL, NC 28227		
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	D BE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	
{F 684}	Continued From pag	e 2	{F 684	}		
	revealed that Reside	nt #1 was cognitively		that lead to the deficiency was deter	mined	
		d limited assistance with		to be the facility's failure to assess for		
	activities of daily livir	g. The MDS further revealed		change of condition when the license	ed	
		clear speech and was		practical nurse (LPN, Nurse #1) did	not	
	usually understood b	y others.		report to a registered nurse (RN) for		
				re-assessment of Resident #1 after		
	Review of a Nurse P	ractitioner (NP) progress		receiving reports of the resident sho	wing	
	noted dated 05/11/18 at 11:46 AM read, Resident			signs of facial drooping and drooling		
	#1 was seen for acute care. Medications,					
	laboratory values, ar	nd notes were reviewed. Staff				
	noted that Resident	#1 has had change in mental				
		ng difficulty speaking.		The procedure for implementing to the control of the control	he	
		y confused and was not		acceptable plan of correction for the		
	interacting with me w			specific deficiency cited		
		d Resident #1 was calm and				
	=	d. Review of a urinalysis		On 5/10/18, the minimum data set (N	MDS)	
		e) revealed it was positive for		nurse's care plan – General Note		
		at could indicate a urinary		indicated Resident #1 was at baseling		
		itrites (a cell that could		did not indicate Resident #1 with fac		
	indicate a urinary tra	The state of the s		drooping or other change in conditio	n.	
		read, Urinary tract infection				
		efuses to take medications by		On 5/11/18 earlier in the day before		
	-	in (antibiotic) 1 gram (gm)		AM, Nurse #1 did observe Resident		
	intramuscular (IM) ev	very day for 3 days.		change in clarity of speech, but did r		
		1 1 1 30 0 ND		see any facial drooping or drooling,		
		nducted with the NP on		then called the nurse practitioner to	-	
		. The NP stated that on		the nurse practitioner would be at the		
		ated "something was wrong"		facility on 5/11/18. Nurse #1 is a LPN		
		e NP stated she went to see		it is not in the scope of practice for a	n	
		luated her and reviewed her		LPN to assess.		
		ne laboratory values indicated		On E/11/19 at approximately 11:40 A	N	
		nd she was not her usual		On 5/11/18 at approximately 11:46 A		
		The NP stated at the time		the physician extender nurse practiti		
		ent #1 she had no slurred		(NP) note indicated Resident #1 was) SCCII	
		signs that indicated she may		by the NP. The NP note indicated "Patient seen for acute care. Meds, I	ahe	
	_	stroke or she would have sent ospital. She indicated that her		notes reviewedalert, confusedU	·	
		ew of her medical record		reviewed, + for leukocytes, positive f		
		ent #1 had a UTI and she		nitratespatient refuses PO medica		
	ו וווטוטמנכט נוומנ הכטוטנ	nii mi nau a o n anu sne	1	I mulatespatient refuses e o medica	ແບກວ,	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
						R-C	
		345562	B. WING	B. WING		05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	ÞΕ		
CLEARC	DEEK MUDEING 8 DEU	ADII ITATION CENTED		10506 CLEAR CREEK COMMERCE DR	IVE		
CLEAR CI	REEK NURSING & REH.	ABILITATION CENTER		MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
{F 684}	Continued From pag	ne 3	{F 684	13			
	confirmed that she w	phin for 3 days. The NP also vas not alerted to any other red with Resident #1 that		give Rocephin 1 gram IM q24 give with lidocaine." The NP indicate Resident #1 with right drooping.	note did not		
	Aide (RA) on 05/29/stated that on 05/11/the facility. While we approximately 1:00 I Resident #1 was not agitated her speech RA indicated that shwheelchair to Nurse speech was slurred sherself. She stated N was aware of Resident #1 back to An interview was con 05/29/18 at 3:40 PM arrived at the facility 2:45 PM and noticed the halls hollering busense. She further in	Inducted with the Restorative 18 at 6:30 PM. The RA 18 she was doing weights in 18 ighing Resident #1 at 18 M the RA noted that 19 acting like herself, she was 19 was slurred and muffled. The 19 e pushed Resident #1 in her 19 and informed her that her 19 and informed her that her 19 and she was not acting like 19 Jurse #1 indicated that she 19 ent #1's condition and pushed 19 wards her room. 10 Justice #1 indicated she 10 on 05/11/18 at approximately 10 Justice #1 rolling around 10 ut nothing she said made any 10 indicated that Resident #1 was 10 und in the air and was		On 5/11/18 at approximately restorative aide noticed Resid speech was not clear while wand took the resident to Nurs. On 5/11/18, at approximately restorative aide witnessed Nulooking at Resident #1 and with Nurse #1 transport Resident nurse station for observation. did not document her observation. did not document her observation. Resident #1 in the electronic record. Not recognizing there change of condition, LPN #1 a registered nurse (RN), NP, (MD) to re-assess Resident #1 afternoon as the day progres 5/11/18. On 5/11/18 at approximately different resident's family mer	dent #1's reighing her e #1. 1:00 PM, the urse #1 atched #1 to the Nurse #1 ation of health e was a did not notify or physician #1 in the sed on		
	drooling and her mobut she could not restated she saw Nurs think Resident #1 is stated that Nurse #1 of it" and that was it. the day she told Visiwrong with Resident not see Nurse #1 goduring her time in the	uth was drawn to one side call which side. Visitor #1 e #1 and stated to her "I having a stroke." Visitor #1 replied "we are taking care Visitor #1 stated that later in tor #2 that something was #1. Visitor #1 stated she did and check on Resident #1		reported that she attempted to Nurse #1 regarding Resident #1 stated she could not recal visitor interaction. On 5/11/18 after 5:00 PM, the reported to Nurse #1 that Resident was exhibiting slouched post and slurred speech. Nurse # NP assessed the resident in and Resident #1 was on antition a urinary tract infection.	o approach #1. Nurse I this specific e therapist sident #1 ure, drooling 1 stated the the morning		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C	
	345562	B. WING			
NAME OF PROVIDER OR SUPPLIER	3.5552	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	05/31/2018	
NAME OF TROVIDER OR OUT FIELD					
CLEAR CREEK NURSING & RE	HABILITATION CENTER		10506 CLEAR CREEK COMMERCE DRIVE		
			MINT HILL, NC 28227		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
{F 684} Continued From page 5	age 4	{F 684	1}		
arrived at the facilii 5:00 PM and was is something was wristated that she obside wheelchair and was but her speech was Visitor #2 stated shelp Resident #1 at (PT) #1 and #2 and Resident #1. An interview was of #2 on 05/29/18 at 05/11/18 at approximate to the theraph Resident #1 had shoop and was droop and w	ty on 05/11/18 at approximately informed by Visitor #1 that ong with Resident #1. Visitor #2 served Resident #1 in her is making all kinds of noises is slurred and she couldn't talk. The went to look for someone to and found Physical Therapist in disked them to check on the conducted with PT #1 and PT 5:30 PM. PT #1 stated that on imately 5:30 PM Visitor #2 by gym and stated that surred speech, she had facial oling. PT #1 indicated that she in the country of the coun	{F 684	On 5/11/18 at approximately 6:00 P Nurse #1 administered an antibiotic injection for Resident #1. At that tin Nurse #1 did not note observing factoroping or drooling. On 5/11/18 at the 7 PM shift change Nurse #1 reported to medication aid (MA) #1. Nurse #1 and MA #1 did report to a RN Resident #1's change condition (right facial drooping, droof and continued slurred speech) for assessment, failing to follow establic policy. On 5/12/18 at approximately 10:08 RN #1 assessed Resident #1. The assessment revealed Resident #1. The assessment revealed Resident #1's physician/nurse practitioner provide provider gave an order to send Resident #1's resident representative (RR)/daughter. RN #1 also contacted Resident #1's resident representative (RR)/daughter. RN #1 sent Resident to the ED as ordered by the provide RR met Resident #1 at the ED. The resident representative/daughter representative/daughter representative/daughter also report noticing right facial drooping on the morning of 5/12/18. On 5/12/18 through 5/16/18, the ED physician evaluation, including labo	ne, ial a, le not e in bling, shed AM, had a oping). r. The ident D) for //e nt #1 r. The e coorted 1 was ht ed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCT A. BUILDING			(X3	(X3) DATE SURVEY COMPLETED	
			A. BOILDII	10		R-C	
		345562	B. WING _			05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
CLEARC	DEEK MIIDGING 8 DEU	ADII ITATION CENTED		10506 CLEAR CREEK COMMERC	E DRIVE		
CLEAR C	REEK NURSING & REH	ABILITATION CENTER		MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
{F 684}	and Resident #1 wa medications. Nurse the RA brought Resi was not acting like his lurred. Nurse #1 indicated the stated that later in and stated that Resi herself and was exh droop, and drooling. replied to PT #1 and been assessed and Nurse #1 stated that to go and assess Residens.	ge 5 the was passing medication is not prescribed any the stated around lunch time ident #1 to me stated that she iterself and her speech was adicated she was aware of her that the NP had seen her and protection for a UTI. Nurse #1 in the day two PTs had come dent #1 was not acting like ibiting slurred speech, facial Nurse #1 stated that she is that she had already she was being taken care of it she did not think she needed esident #1 because the NP and the stated in the day.	{F 6	cerebrovascular (CVA), far has been normal excesshe has been hypertensistarted on antibiotics for infections yesterday." O physician orders were ging Resident #1 back to the medications ordered. The diagnoses of CVA, do not (DNR), dementia, hyperthypertension are listed of discharge summary. Resincluded acute cystitis with a discharge in hospice evaluation.	ept the fact that ive, was also her urinary tract in 5/12/18, wen to discharge facility with none discharge of resuscitate ipidemia, and on the hospital solved diagnosis ithout hematuria. returned to the		
	#1 on 05/31/18 at 10 again that she had r a change in conditionurse to assess Resthat the RA, Visitor reported their conce #1's slurred speech, but she believed that her UTI. Nurse #1 si brought Resident #1 did not see Residen she went to adminis injection and at that change to her conditional An interview was conditional Assistant (NA) #1 or #1 confirmed that she was expected.	was conducted with Nurse 0:26 AM. Nurse #1 confirmed not assessed Resident #1 for n and did not ask any other sident #1. She acknowledged #1, PT #1 and #2 had rns to her about Resident facial droop, and drooling tt they were all effects from tated that after the RA to her earlier that day she tt #1 again until 6:00 PM when ter her ordered antibiotic time she did not notice any tion. nducted with Nursing n 05/30/18 at 12:54 PM. NA ne took care of Resident #1 and 2nd shift. She stated that		3. The monitoring proof that the plan of correction that specific deficiency of corrected and/or in compregulatory requirements On 5/30/18, the MDS RN nurse RN assessed each RN assessment of each taking vital signs, pain, a for change in condition. The assessment was to put and other residents in situations. The findings of assessments: no current have a new/previously up in condition requiring addressessment or physician	n is effective and ited remains oliance with the soliance with the soliance with the soliance with the resident. The resident included and mental status. The purpose of protect Resident in similar of the stacility residents indentified changeditional	5	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
						R-C	
		345562	B. WING _			05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER	-	<u>'</u>	STREET ADDRESS, CIT	Y, STATE, ZIP CODE	00.01.2010	
				10506 CLEAR CREEK	COMMERCE DRIVE		
CLEAR C	REEK NURSING & RI	EHABILITATION CENTER		MINT HILL, NC 282			
(X4) ID	SUMMAR'	Y STATEMENT OF DEFICIENCIES	ID	PROVID	DER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG	(EACH CO	RRECTIVE ACTION SHOULD BI FERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION	
{F 684}	Continued From p	page 6	{F 6	34}			
	speech was slurre	ed and she was drooling from		On 5/30/18, the	e director of nursing (DO	N)	
	·	outh. NA #1 stated that she			ducation with all nursing	,	
	alerted Nurse #1 a	and was told that Resident #1		I	nursing assistants (NAs	s),	
	had already been	evaluated by the NP and was			d RNs. The re-education		
	· -	a UTI. NA #1 stated that she		covered the top	oic of "Notification."		
		t1 in the bed per her usual		"Notification of	changes, Notification of		
	routine and when	she left her shift at 11:00 PM on		MD/NP and RF	P. When alerted of a		
	05/11/18, Residen	nt #1 was resting in bed with her		change in a res	sident, complete an		
	eyes closed.			assessment an	nd document. Reporting		
				changes includ	le bruises of unknown		
		conducted with NA #2 on		origin"			
		AM. NA #2 confirmed that she					
		n 05/11/18 and stated that			e facility administrator ar	ıd	
		d in bed the entire night and			with the regional vice		
		anything different with her. NA			P) and corporate facility		
		rendered incontinent care to			e RVP and corporate		
		proximately 5:00 AM on			ant re-educated the	.	
		ng that interaction she did not			nd DON. The re-educat		
		pehavior or anything out of the			oics of Quality of Care an	1d	
		ent #1. She added that if she			its for Notification of		
		ed any abnormal behavior she			ddition, the RVP and	.:41-	
	would have alerte	a the hurse.			ty consultant reviewed w		
	An interview was	conducted with Nurse #2 on			or and DON topics of: 1	-	
		PM. Nurse #2 confirmed that		_	idition policy, 3) failure to nge of condition resulting		
		rd shift on 05/11/18 and was			follow established policy		
	_	esident #1. Nurse #2 stated that			ortance of addressing	'	
		vas notified that Resident #1			concerns related to qua	lity	
		ng like herself but had been		of care.	concerns related to qua	"ity	
		NP and was on antibiotic for		or care.			
	1	ted that Resident #1 rested		On 5/30/18, the	e corporate facility		
		that the never had to interact			ated a 100% audit of the		
	, ,	that night. He added that NA #2			notes from 5/1/18 throu		
		unusual behavior that evening			ourpose of the audit was	_	
		al night for Resident #1.			eded resident assessme		
		-		1	or other resident at risk		
	An interview was	conducted with Nurse #3 on			ndition that has not beer		
		PM. Nurse #3 confirmed that			addressed through		
		/18 on 1st shift and was			rovider notification and I	RR	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
		345562 B. WIN		. WING			R-C	
		345562	D. WING _			05/	31/2018	
NAME OF PR	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CLEAR CE	REEK NURSING & REHA	ABII ITATION CENTER		10	0506 CLEAR CREEK COMMERCE DRIVE			
OLLAIT OI	KEEK HOROMO & KEI	ABILITATION GENTER		M	IINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 684}	Continued From pag	ne 7	{F 6	84}				
, ,		dent #1. Nurse #3 stated that		٠,	notification. Any resident needing			
	T	AM Resident #1's family			assessment will be assessed by a RN	and		
		asked that Resident #1's			notifications made to the care provider	ana		
		ed because there was			and RR.			
		th her. Nurse #3 stated that			and rec			
		esident #1 prior to the family			On 6/22/18, the corporate facility			
		ck Resident #1's vital sings.			consultant re-educated the			
	_	when she went to obtain			Interdisciplinary Team (IDT)- that include	des		
		igns she did not notice any			but not limited to the DON, Staff			
		op. She stated that she			Development Coordinator (SDC),			
	-	smile and she did and she			treatment nurse, MDS Nurse, unit			
	asked Resident #1 to	o lift both her arms in the air			manager, activity director, rehab			
	and she was able to	do that. Nurse #3 stated that			representative and social services- on	the		
	her assessment reve	ealed no change in Resident			morning clinical meeting format, and			
	#1 from her baseline	but the family requested that			follow up items process. Newly hired IE	T		
	Resident #1 be sent	to the Emergency Room			members will receive training on the			
	(ER) for evaluation a	and so she sent her out.			morning clinical meeting during orienta by the SDC.	tion		
	An interview was cor	nducted with Resident #1's						
	family on 05/29/18 a	t 2:17 PM. The family			The nurse that is assigned to the reside	ent		
	member stated that s	she had visited Resident #1			is responsible for the assessment of the	е		
	on 05/10/18 and four	nd her to be in her usual			resident when a change of condition ha	as		
	state of health. The f	family member stated that			been identified. If the change occurs			
	she came to the facil				during a time when a RN is not on duty	· —		
		AM and was sitting in the			the licensed nurse or the MA will call th			
		on the staff to get her family			RN on call and relay the pertinent data			
		ne added that Visitor #1 came			The on-call RN will then be responsible	;		
		family member of what she			for completing the assessment of the			
		5/11/18 with Resident #1. The			resident.			
	-	d that when Nurse #3						
		ember into the dining room			On 6/25/18, the DON began to re-educ			
		er for the first time that day			the MAs, LPNs, and RNs on the proces			
	_	her mouth was drawn to the			for assessment and change of conditio			
	_	ated she asked Resident #1			and notification to the physician, physic	cian		
		Resident #1 stated "no I am			extender and resident representative.	d = =		
	_	#1's family member stated to			Newly hired nurses and medications ai	ues		
	_	ily member ok she looks like			will receive the education on the	nd		
		e" and Nurse #3 replied "she morning." Resident #1 stated			assessment and change of condition a notification during their orientation period			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345562 B. WIN		WING			R-C 05/31/2018	
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 03/	31/2010	
					506 CLEAR CREEK COMMERCE DRIVE			
CLEAR C	REEK NURSING & REI	HABILITATION CENTER			NT HILL, NC 28227			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG			PREFI) TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
{F 684}	Continued From pa	ge 8	{F 68	84}				
	she informed Nurse	#3 she wanted her family						
	member sent out to			The facility IDT will review in morning				
	they did.				clinical meeting the progress notes dat	ed		
					from previous to current meeting to			
		onducted with NA #3 on			determine potential changes of condition	ons		
	05/31/18 at 1:24 PM. NA #3 confirmed that she				in resident conditions to include			
	was working on 05/12/18 on 1st shift. NA #3 stated that Resident #1's family asked her to go				notification of physician and or physicia			
	and look at Resident #1. NA #3 stated that the				extender and resident representative. review will include copies of physician	ine		
		she noticed her face was			orders, clinical alerts that include meal			
		ide and she looked like			intake, skin alerts, incidents, care plan			
	_	a stroke. NA #3 stated that			updates or revisions, and resident and	or		
	she summoned the	Director of Nursing (DON) to			family concerns. The DON will docume	ent		
		esident #1 and she had her			any follow up items that require			
	sent to the ER for e	valuation.			completion by end of day. The results	of		
	A :	and a standard the DON an			the daily IDT team meeting will be			
		onducted with the DON on M. The DON stated that on the			communicated to the administrator.			
		3 she arrived at the facility and			To maintain continued the results of the	_		
	_	that Resident #1's family			follow-up items and compliance will be			
		facility and thought Resident			submitted to the facility's QAPI (quality			
		oke. The DON stated she			assurance/performance improvement)			
	immediately procee	ded to go and check on			Committee monthly for three months th	nen		
		tially by looking at her could			quarterly for review and guidance. If			
		s wrong but when Resident #1			additional issues are noted, those issue	es		
	· ·	e knew something was not			will be addressed immediately and			
	_	ed that Resident #1's speech			corrective action taken.			
		d she asked if the medics he added that Nurse #3 stated						
		ne way to the facility and						
		ansported to the ER for			4. The title of the person responsible f	or		
		N stated she was not aware			implementing the acceptable plan of			
	that on 05/11/18 so	metime after Resident #1 was			correction.			
	-	P she began to have facial						
		and if these symptoms were			The administrator will be implementing			
	_ ·	sing staff they should have			and is responsible for implementing the	9		
	contacted her.				acceptable plan of correction.			
	An interview was co	onducted with the Medical						

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE SURVEY COMPLETED	
		345562 B. WING			R-C		
NAME OF P	ROVIDER OR SUPPLIER	0.0002		STREET ADDRESS, CITY, STATE, ZIP COD		05/31/2018	
CLEAR CREEK NURSING & REHABILITATION CENTER			10506 CLEAR CREEK COMMERCE DRI MINT HILL, NC 28227	VE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
{F 684}	stated that if Reside droop, drooling, and all classic signs of a these symptoms we staff on 05/11/18 the should have been mediately out to the Resident #1 had retineurologically and pwhile working with the Resident #1 present brain was abnormal could not determine because we could noccurred or how old #1's advanced age for the treatment of (TPA) (treatment for Review of the dischange of her head revindeterminate lacunbasal ganglia and rights and presented to scan of her head revindeterminate lacunbasal ganglia and rights and presented to scan of her head revindeterminate lacunbasal ganglia and rights and presented to scan of her head revindeterminate lacunbasal ganglia and rights and presented to scan of her head revindeterminate lacunbasal ganglia and rights and presented to scan of her head revindeterminate lacunbasal ganglia and rights and presented to scan of her head revinded CVA (stroked). An observation was 05/30/18 at 12:10 Pher wheelchair in the calm and no facial did An observation was 05/31/18 at 8:00 AM the breakfast table was significant.	BO/18 at 12:10 PM. The MD nt #1 began to display facial slurred speech those were stroke. The MD stated that if are reported to the nursing ande aware so Resident #1 evaluated and sent the ER. The MD stated that the ER. The MD stated that the early and had done well the early. He added that when are do to the ER her scan of her and indicated a stroke but how old. The MD added that of identify when the stroke it was along with Resident she would not have qualified tissue plasminogen activator stroke). For a stroke in the ER on 05/12/18 and vealed punctate age ar infarcts (stroke) in the right ght thalamus (parts of the ng diagnoses to the facility	{F 68	44}			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG	(X3	(X3) DATE SURVEY COMPLETED	
		345562	B. WING			R-C 05/31/2018
	ROVIDER OR SUPPLIER	IABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227		•	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 684}	The plan should add to the deficiency cite On 5/30/18, Clear C Rehabilitation Center Jeopardy at 5:00 Pl of Care. The process was determined to be assess for change of practical nurse (LPN a registered nurse (Resident #1 after resident #1 after resident processed than the showing signs of fact that the showing signs of fact	crecting the specific deficiency. dress the processes that led dreek Nursing and er was placed into Immediate of for failing to provide Quality is that lead to the deficiency the facility 's failure to of condition when the licensed of Nurse #1) did not report to RN) for re-assessment of ceiving reports of the resident cial drooping and drooling. ed the resident 's change in red the nurse practitioner tent 's needs by performing prescribing an antibiotic for	{F 68	<u> </u>		
	acceptable plan of of deficiency cited On 5/10/18, the MD Note indicated Residid not indicate Resor other change in COn 5/11/18, earlier in Nurse #1 did observing clarity of speech and deficiency cited to the control of the contro	s for implementing the correction for the specific S nurse's Care Plan - General dent #1 was at baseline and ident #1 with facial drooping condition. In the day before 11 AM, we Resident #1's change in did not see any facial gearlier in the day and did call				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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		345562	B. WING	-	0	5/31/2018	
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE		
0. = 4 = 0			10506 CLEAR CREEK COMMERC		E DRIVE		
CLEAR C	REEK NURSING & RE	HABILITATION CENTER		MINT HILL, NC 28227			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
{F 684}	the nurse practition practical nurse (LF practice for an LPI there was a change notify a registered (NP), or physician in the afternoon as 5/11/18. On 5/11/18 at app Physician Extended indicated Residen NP note indicated Meds, labs, notes UA reviewed, + 10 nitrates patient in Rocephin 1-gram lidocaine." The NI #1 with right facial On 5/11/18 at app restorative aide nowas not clear while resident to Nurse #1 nurse station for or document an asserted not the sident #1. Nurse recall this specific On 5/11/18 after 5 to Nurse #1 that R slouched posture,	PN) and it is not in the scope of N to assess. Not recognizing to of condition, LPN #1 did not nurse (RN), nurse practitioner (MD) to re-assess Resident #1 to the day progressed on toximately 11:46 AM, the ter nurse practitioner (NP) note to the thick was seen by the NP. The "Patient seen for acute care. The reviewedalert, confused for leukocytes, positive for efuses PO medications, give limited and indicate Resident drooping. Toximately 1:00 PM, the street weighing her and took the level of the thick weighing her and took the level of the weighing her and took the level of the l	{F 6		NCT)		
	lidocaine." The N #1 with right facial On 5/11/18 at app restorative aide no was not clear while resident to Nurse #1 nurse station for o document an asse record. On 5/11/18 at app resident's family m attempted to appro Resident #1. Nurs recall this specific On 5/11/18 after 5 to Nurse #1 that R slouched posture, Nurse #1 stated th the morning and R therapy for a urina	P note did not indicate Resident drooping. roximately 1:00 PM, the sticed Resident #1's speech weighing her and took the #1. The restorative aide #1 looking at Resident #1 and transport Resident #1 to the bservation. Nurse #1 did not essment in the electronic health roximately 2:45 PM, a different member reported that she pach Nurse #1 regarding se #1 stated she could not visitor interaction. 100 PM, the therapist reported esident #1 was exhibiting drooling and slurred speech. 101 PM assessed the resident in Resident #1 was on antibiotic					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345562	B. WING		R-C			
NAME OF PROVIDER OR SUPPLIER CLEAR CREEK NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIV		DE			
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{F 684}	#1. At that time, Nu facial drooping or d On 5/11/18 at the 7 reported to medical and MA #1 did not (RN) Resident #1's facial drooping, dro speech) for assess established policy. On 5/12/18 at appropriete appropriete assessment rechange in condition contacted Resident practitioner provide to send Resident # department (ED) for contacted Resident (RR)/daughter. RN ED as ordered by the Resident #1 at the representative/daughysician that Resi 5/10/18. The residualso reported notici morning of 5/12/18 On 5/12/18 through evaluation, including results indicated no had a cerebrovascu far has been normal been hypertensive, for her urinary tract 5/12/18, physician Resident #1 back to medications ordered of CVA, DNR, demonstrated to medications ordered to the medications ordered to the medications ordered to the medications ordered to the medications or demonstrated to the medicati	itibiotic injection for Resident burse #1 did not note observing rooling. PM shift change, Nurse #1 ition aide (MA) #1. Nurse #1 report to a registered nurse change in condition (right oling, and continued slurred ment, failing to follow eximately 10:08 AM, N) #1 assessed Resident #1. vealed Resident #1 had a continued representative in the emergency in evaluation. RN #1 also is #1's resident representative in #1 sent Resident #1 to the energency in evaluation. RN #1 also is #1's resident representative in #1 sent Resident #1 to the energency in evaluation. The RR met is ED. The resident ghter reported to the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent representative/daughter in gright facial drooping on the instance of the ED dent #1 was at baseline on ent rep	{F 684					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL IDENTIFICATION NUMBER: A. BUILD		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345562	B. WING			R-C 05/31/2018		
NAME OF PROVIDER OR SUPPLIER CLEAR CREEK NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZI 10506 CLEAR CREEK COMMERC MINT HILL, NC 28227		03/31/2016		
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{F 684}	cystitis without hemae #1 returned to the fainstruction for hospid. 3. The monitoring plan of correction is deficiency cited remacompliance with the On 5/30/18, the mini wound nurse RN ass RN assessment of evital signs, pain, and condition. The purpot to protect Resident # similar situations. The assessments: no cunew/previously unide requiring additional anotification. On 5/30/18, the direct a re-education with anursing assistants (NThe re-education composition). "Notification." "Notification of changand RP. When alert complete an assessing Reporting changes in origin" On 5/30/18, the facility consulted with the reand corporate RN fain and corporate consulted with the reand corporate consulted the topics of covered the topics of the simple results of	diagnosis included acute aturia. On 5/16/18, Resident cility with discharge se evaluation. procedure to ensure that the effective and that specific ains corrected and/or in regulatory requirements mum data set (MDS) RN and sessed each resident. The ach resident included taking mental status for change in ose of the assessments was at and other residents in e findings of the rrent facility residents have a contified change in condition assessment or physician/NP actor of nursing (DON) initiated all nursing staff to include JAs), MAs, LPNs, and RNs. wered the topic of ges, Notification of MD/NP ed of a change in a resident,	{F 6	84}				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345562	B. WING				-C 31/2018
	ROVIDER OR SUPPLIER	BILITATION CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 0506 CLEAR CREEK COMMERCE DRIVE IINT HILL, NC 28227		
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{F 684}	reviewed with the adrof: 1) Change in Conassess for change of failure to follow establimportance of address concerns related to Con 5/30/18, the corporation and the number of the number of the second of the secon	d corporate consultant ministrator and DON topics dition policy, 3) failure to condition resulting from lished policy, and 4) the sing resident/family	{F 6	84}			
{F 867} SS=D	implementing the acc The administrator will responsible for impler of correction. Immediate jeopardy v 5:53 PM when intervi revealed that they ha conducting assessme condition was reporte included if the nurse resident that the expet to a nurse that could QAPI/QAA Improvem CFR(s): 483.75(g)(2)	ents when a change of ed. The education also was unable to assess the ectation was that they report assess the resident.	{F 8	367}			6/29/18

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER CLEAR CREEK NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227			03/31/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE TO THE APPROPRIATE EIENCY)	(X5) COMPLETION DATE		
{F 867}	Continued From pag	e 15	{F 86	67}				
	assurance committee (ii) Develop and impl action to correct iden This REQUIREMEN' by: Based on observation visitor, family, Nurse Doctor interviews the Assessment and Assemaintain implemente these interventions the place in April 2018 for recertification and con deficiency is in the air This deficiency was a current follow up and continued failure of the surveys of record shows	ement appropriate plans of stified quality deficiencies; I is not met as evidenced ons, record review, staff, Practitioner, and Medical efacility 's Quality surance Committee failed to ded procedures and monitor that the committee put into		F 867 QAPI Committee The plan of correcting t deficiency The position of Clear C Rehabilitation center re process that lead to the failed to maintain imple procedures and monito was failure to follow est policy related to quality assurance/performance process (QAPI).	the specific reek Nursing and egarding the deficiency of mented in interventions - tablished facility			
	The findings included This tag is cross refe			The procedure for imple acceptable plan of correspecific deficiency cited	ection for the			
	staff, visitor, family, Medical Doctor intervassess a resident that symptoms of cerebro for 1 of 3 residents s (Resident #1). During the recertificate regulation was cited appropriate size of w	ervations, record reviews, Nurse Practitioner, and views the facility failed to at exhibited signs and evascular accident (stroke) ampled for quality of care tion survey of 04/18/18, this for failing to provide the cheel chair for proper body campled residents who		On 6/20/18, the facility Committee held a meet purpose and function of Committee and review compliance issues. The director of nursing (DOI set (MDS) nurse, staff f maintenance director, cactivities director, qualit (QI) nurse and houseke will attend monthly and committee meetings on	ting to review the f the QAPI on-going e Administrator, N), minimum data facilitator, dietary manager, ty improvement eeping supervisor quarterly QAPI			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	040002	STREET ADDRESS, CITY, STATE, ZIP CODE			1 05/	31/2018	
CLEAR CREEK NURSING & REHABILITATION CENTER					0506 CLEAR CREEK COMMERCE DRIVE IINT HILL, 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				(X5) COMPLETION DATE	
{F 867}	#48). An interview was con Administrator on 05/3 Administrator stated I a couple of months an Assessment (QA) me was held monthly and Administrator, Director	ducted with the 1/18 at 6:38 PM. The ne had been at the facility for nd he oversaw the Quality eting. He explained that it d consisted of the or of Nursing, all department	{F 8	67}	and will assign additional team member as appropriate. On 6/20/18, the facility quarterly Executed QAPI Committee held a meeting to reverthe tags from the most recent survey at go over the general plan of correcting the deficiencies with the medical director at corporate facility consultant. On 6/20/18, the corporate facility	itive riew nd :he		
	pharmacist, and Regi Administrator explain was 05/16/18 and the their recertification su audits and monitoring that the audits were g holding all staff even so that the facility cou they want. The Admir ad hoc meetings as n a soft spot or area of together and discuss often they will seek th Director. The Adminis be meeting with his te survey results and to	deads, medical director, nurse practitioner, sharmacist, and Registered Dietitian. The Administrator explained that their last meeting was 05/16/18 and they discussed the results of heir recertification survey and discussed how the audits and monitoring tools were going. He added that the audits were going well and he was nolding all staff even weekend staff accountable to that the facility could achieving the compliance they want. The Administrator added that they hold ad hoc meetings as needed if the team identity 's a soft spot or area of concern the team will come together and discuss the issue. He added that soften they will seek the advice of the Medical Director. The Administrator stated that he would be meeting with his team soon to discuss the survey results and to formulate a plan that would other the team in the right direction.			consultant in-serviced the outgoing administrator and oncoming administrator related to the appropriate functioning of the Executive QAPI Committee and the purpose of the committee to include identifying issues and correct repeat deficiencies related to F 684. On 6/20/18, the administrator in-service the department heads related to the appropriate functioning of the QAPI committees and the purpose of the committees and the purpose of the committees to include identifying issue and correct repeat deficiencies related F684. As of 6/20/18 after the facility consultar in-service, the facility QAPI committee begin identifying other areas of quality concern through the QAPI review process, for example: review of rounds tools, review of work orders, review of Point Click Care (electronic health record), review of resident council minutes, review of resident concern log review of pharmacy reports, and review regional facility consultant recommendations.	of eed s to nt will		

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NAME OF P	ROVIDER OR SUPPLIER	343302	B: WillO _	STREET ADDRESS, CITY, STATE, ZIF	P CODE	05/31/2018
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CLEAR C	REEK NURSING & RE	HABILITATION CENTER		MINT HILL, NC 28227		
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{F 867}	Continued From pa	age 17	{F 86		Il meet at a Executive QA inimum of es related to e, safety, trend p and implementions plans for s. en taken for the ed to F 684. The to ensure the effective and the remains correct the the regulator mmittee which d to the director, Quality or, Social Work macist ords Director, usekeeping to meet at a review esident care, y, medical , activities, soci ident and fami committee which d to the f Nursing, Soci or, Infection nce Director,	ds, ent e at nat cted y cer, cial illy ch ial

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NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
CLEAR C	REEK NURSING & REHA	BILITATION CENTER		10	0506 CLEAR CREEK COMMERCE DRIVE				
CLLANC	KLEK NOKSING & KENA	BEHATION CENTER		M	IINT HILL, NC 28227				
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{F 867}	Continued From page	e 18	{F 8	67}	members as assigned by the Administrator. The QAPI committee will continue to meet monthly to discuss the QI Program progress that is centered of the needs and desires of our resident. The QAPI Committee reviews progress the standing QI committees with oversity a corporate staff member. The Executive QAPI Committee, include the medical director, will review quarter compiled QAPI report information, reviet rends, 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 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 correction.	e on s of ight ling ew e e			