

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 345562	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/28/2020
NAME OF PROVIDER OF SUPPLIER CLEAR CREEK NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP 10506 CLEAR CREEK COMMERCE DRIVE MINT HILL, NC 28227	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0564 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Inform each resident of his or her visitation rights and ensure that all visitors enjoy equal visitation privileges.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on record review, family and staff interviews, and review of the facility posting Coronavirus Guidance, the facility failed to allow a [MEDICATION NAME] care visit by family for 1 of 3 residents (Resident #1) reviewed for end of life care. Findings included: A facility posting titled Coronavirus Guidance- Visitation Restriction at This Time, last updated [DATE] was reviewed. The posting read in part: Visitation will only be arranged if patient is at End of Life and must be scheduled in advance Resident #1 was admitted to the facility on [DATE] and expired at the facility on [DATE]. Her [DIAGNOSES REDACTED]. #1 had a Medicare/ 5-day Minimum Data Set ((MDS) dated [DATE] which revealed moderate impairment for decision making. A telephone interview was completed on [DATE] at 11:57 AM with a family member of Resident #1. The family member expressed they were notified on [DATE] that Resident #1 was not doing well. The family member asked if they could visit Resident #1 and was informed by facility staff due to Resident #1 being on the Covid Unit, visitation was not allowed. The family member could not recall who they spoke with at the facility. An interview was completed on [DATE] at 12:15 PM with Nurse #1. She stated she was familiar with Resident #1 and was her assigned nurse during her decline and subsequent death at the facility. Nurse #1 verbalized she communicated with Resident #1's family via telephone calls. Nurse #1 expressed she did not offer [MEDICATION NAME] care visitation to Resident #1's family due to being informed by the Covid Unit Manager [MEDICATION NAME] care visits were not an option for residents on the Covid Unit. Nurse #1 voiced she was present with Resident #1 when she expired. An interview was completed on [DATE] at 12:32 PM with the Covid Unit Manager. He stated he was familiar with Resident #1. He explained he was not aware of the guidance regarding [MEDICATION NAME] care visitation on the Covid Unit. The Covid Unit Manager voiced he only heard of [MEDICATION NAME] care visitation today ([DATE]). He communicated Resident #1's family was not offered or allowed a [MEDICATION NAME] care visit during her decline and subsequent death at the facility. An interview was completed on [DATE] at 12:45 PM with the Director of Nursing (DON).</p> <p>She explained she was familiar with Resident #1 and voiced she had a rapid decline. The DON communicated residents that were transitioning to end of life, whether on Hospice or not, should be offered [MEDICATION NAME] care visitation. The DON verbalized at end of life the family should be allowed to see their loved one. The DON was not certain as to why a [MEDICATION NAME] care visit was not offered to the family of Resident #1.</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.