STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345562	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clear Creek Nursing & Rehabilitation Center	10506 Clear Creek Commerce Drive Mint Hill, NC 28227

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Nurse Practitioner interviews, the facility failed to remove an indwelling urinary catheter per the physician's order and failed to keep a urinary catheter drainage bag and tubing from touching the floor to reduce the risk of infection for 1 of 4 residents reviewed for urinary catheters (Resident #36). The findings included: Resident #36 was admitted to the facility on [DATE] with diagnoses that included history of stage 3-4 pressure ulcer. The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #36 was moderately cognitively impaired and was coded for having an indwelling urinary catheter. The care plan dated 01/02/25 revealed Resident #36 had an indwelling urinary catheter due to a stage 4 sacral wound and the interventions included providing catheter care per the physician orders. Resident #36 had a physician order dated 03/11/25 that read; discontinue the indwelling urinary catheter on 03/15/25. The order was entered by Nurse #3. Resident #36's medication administration record (MAR) indicated the indwelling urinary catheter was removed on 03/15/25 by Nurse #6. a. An observation conducted on 03/17/25 at 10:21 AM revealed Resident #36 was lying in bed resting and had an indwelling urinary catheter draining to a bedside drainage bag. An interview with Nurse #3 on 03/19/25 at 12:20 PM revealed on 03/11/25 a member of the nurse management team, she did not recall their name, asked her to obtain a physician's order to remove Resident #36's indwelling urinary catheter. Nurse #3 stated she called the Nurse Practitioner and obtained an order to remove Resident #36's indwelling urinary catheter on 03/15/25. Nurse #3 indicated she entered the order into the electronic medical record, but she was not Resident #36's assigned nurse on 03/15/25 and was unsure if the urinary catheter was removed. (continued on next page)

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.

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A phone interview with Nurse #6 on 03/20/25 at 8:04 AM indicated she was the 3rd shift (11pm-7am) nursing supervisor on 03/14/25 to 03/15/25. She indicated she did not recall seeing an order to remove Resident #36's indwelling urinary catheter on 03/15/25 nor did she remove the catheter. Nurse #6 was unable to explain why it was documented on the MAR that she completed the order to remove Resident #36's indwelling urinary catheter. During an interview with Nurse #5 on 03/20/25 at 9:03 AM she indicated she was Resident #36's assigned nurse on 3/17/25. Nurse #5 revealed a nurse, she did not recall her name, informed her that Resident #36 had an order to remove Resident #36's indwelling urinary catheter on 03/15/25 that was not completed. Nurse #5 stated she removed Resident #36's indwelling urinary catheter on 03/17/25 at approximately 10:30 AM. An interview conducted with the Nurse Practitioner (NP) on 03/19/25 at 10:16 AM revealed she received a phone call from the facility on 03/11/25 requesting an order to remove Resident #36's urinary catheter because there was not a supporting diagnosis for the use of the catheter. The NP indicated she ordered Resident #36's indwelling urinary catheter to be removed on 03/15/25. The NP stated she was unaware the order was not completed, and the catheter should have been removed on 03/15/25 as ordered. During an interview with the Director of Nursing (DON) on 03/20/25 at 11:05 AM she revealed Resident #36 had an indwelling urinary catheter in place to assist with healing of a sacral wound. The DON indicated the interdisciplinary care team decided wound healing was not considered to be a supporting diagnosis for the use of an indwelling urinary catheter, so they requested an order from the NP to remove the catheter. The DON indicated she was not aware Resident #36's indwelling urinary catheter was not removed on the order date and that it should have been removed on 03/15/25 as ordered. An interview conducted with the Administrator on 03/20/25 at 1:30 PM indicated an order to remove an indwelling urinary catheter should have been completed on the date the physician ordered it to be removed. b. An observation conducted on 03/17/25 at 10:21 AM revealed Resident #36 was lying in bed resting and had an indwelling urinary catheter draining to a bedside drainage bag. The catheter tubing and bedside drainage bag were observed lying on the floor beside the bed. An interview with Nurse #5 on 03/17/25 at 10:51 AM indicated she was assigned to Resident #36 and entered her room around 10:30 AM to remove the indwelling urinary catheter. She stated the catheter tubing and bedside drainage bag were lying on the floor beside the bed. Nurse #5 indicated the Nurse Aides (NA) were responsible for emptying the bedside drainage bags and usually emptied them at the end of each shift. Nurse #5 was unsure if the drainage bag lying on the floor was last emptied by the 3rd shift NA or the 1st shift NA, but stated it should have been secured under the bed frame and not touching the floor. A phone interview with NA #5 on 03/20/25 at 1:53 PM revealed she was the 3rd shift NA assigned to Resident #36 on 03/16/25. NA #5 stated she emptied Resident #36's bedside drainage bag around 6:00 AM on 03/17/25 prior to the end of her shift and then secured the drainage bag under the bed frame to ensure it was not touching the floor. NA #5 stated when she left Resident #36's room the urinary catheter tubing and bedside drainage bag were not touching the floor. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Several attempts were made to contact NA #4, assigned to Resident #36 on 1st shift on 03/17/25, were unsuccessful. An interview conducted with the Director of Nursing on 03/20/25 at 11:05 AM revealed indwelling urinary catheter tubing and bedside drainage bags should be secured under the bed frame when a resident was in bed and not touching the floor. The DON indicated catheter tubing and drainage bags should not be lying on the floor because of the increased risk of infection. During an interview with the Administrator on 03/20/25 at 1:30 PM he stated urinary catheter tubing and drainage bags should not be lying on the floor due to the increased risk for infection.