

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 05/15/2026
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	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to store, label and date food in 1 of 1 freezer and 1 of 1 walk-in cooler and failed to remove produce with signs of spoilage in the walk-in cooler. These practices had the potential to affect food served to residents. Findings Include: a. During an initial kitchen tour of the walk-in cooler, conducted with the Dietary Manager on 05/11/2026 at 10:25 AM, the following concerns were identified: - Two packages of strawberries were stored in their original packaging. Four strawberries in one package were observed covered with a white, fuzzy substance. The second package contained one visibly spoiled strawberry. - One pack of blueberries was stored in its original packaging. Five blueberries were observed covered with a white, fuzzy substance. - Thirty-eight yellow squash stored in a box was observed wilted and brown in color. - One box containing 30 oranges stored in a box was observed. Five oranges were observed covered with a white, fuzzy substance. - One box containing loose mushrooms was observed with dark brown and wilted mushrooms. - Ten yellow zucchini were observed in a box wilted and brown in color. - Four unopened packs of lettuce in their original packaging were observed dark brown in color and mushy, with liquid present inside the bags. - Three unopened packs of thyme in their original packaging were observed dark brown in color and mushy, with liquid present inside the bags. b. During an initial kitchen tour of the walk-in freezer, conducted with the Dietary Manager on 05/11/2026 at 10:43 AM, the following concerns were identified: - One bag of open french fries had been removed from the original packaging and placed in an unlabeled resealable plastic bag exposed to air, with no open date. - Twelve packs of open and exposed hamburger meat had been removed from the original packaging and placed in an unlabeled resealable plastic bag, with no open date and visible ice crystals present. - One bag of hush opened puppies was stored in its original packaging with no open date. - One bag of 35 opened and exposed chicken breasts was stored in its original packaging, on the top shelf, with no open, and visible ice crystals present. - Two packages of unopened gluten-free bread were stored in its original packaging labeled with an open date of 12/04/2024. - Two packages of open and exposed pancakes were stored in its original packaging with no open date. On 05/11/2026 at 1:45 PM, an interview was conducted with the Dietary Manager. The Dietary Manager stated the kitchen audit was to be completed by the Kitchen Manager on 5/11/2026 and was rotated between himself and the Kitchen Manager. The Dietary Manager revealed produce was commonly delivered spoiled by the food company utilized by the facility and would spoil quickly because the quality of the food did not last long. The Dietary Manager stated all food items stored in the walk-in cooler and freezer should have been labeled and dated when opened, labeled and dated when removed from the original packaging, and discarded once expired. The Dietary Manager further stated food items that were wilted or had a visible white, fuzzy substance should have been discarded. The Dietary Manager stated he and the Kitchen Manager were responsible for completing the cleaning and audits of the kitchen due to the kitchen being short staffed. On 05/11/2026 at 12:00 PM, an interview was conducted with the Kitchen Manager. The Kitchen Manager stated all food items stored in the walk-in cooler and freezer should have been labeled and dated when opened, labeled and dated when removed from the original packaging, and discarded once expired. The Kitchen Manager further stated any food (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	items that were wilted or had a visible white, fuzzy substance should have been discarded. The Kitchen Manager reported she was scheduled to complete her audit and clean the walk-in cooler and freezer on 05/11/2026 but had not yet had the opportunity to do so. She stated audits were completed weekly and rotated between herself and the Dietary Manager. The Kitchen Manager explained the audit process included checking food items for expiration dates, labeling and dating, and identifying spoiled food items. The Kitchen Manager stated when spoiled or expired food items were identified during the audit process, the items were discarded. The Kitchen Manager indicated that during the previous week's audit, wilted and visibly moldy food items had been identified and discarded. On 05/11/2026 at 1:15 PM, an interview was conducted with the Cook's Assistant. The Cook's Assistant reported the Kitchen Manager and Dietary Manager completed weekly audits and kitchen cleaning of the freezer, cooler, and dry storage areas. The Cook's Assistant stated the Kitchen Manager and Dietary Manager consistently educated staff on kitchen expectations and proper cleaning procedures, including properly labeling and dating food items, discarding expired or spoiled food, rotating food items, and maintaining cleanliness of storage areas; however, staff did not always follow expectations. The Cook's Assistant stated she attempted to help in the kitchen and discarded food items that were no longer good, but other kitchen employees did not always do the same. On 05/14/2026 at 3:59 PM, an interview was conducted with the Administrator. The Administrator stated that all food items should be stored properly, labeled with an open date and expiration date, and monitored through daily audits. The Administrator further stated the expectation was for staff to complete routine audits and clean the kitchen and storage areas regularly to ensure food safety standards were maintained.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews, the facility failed to change the pressure ulcer dressing as ordered for 1 of 3 residents reviewed for pressure ulcers (Resident #11). The findings included: Resident #11 was readmitted on [DATE] with diagnoses which included pressure ulcer of the sacral (triangular bones located below the lumbar spine) area (stage 4), neurocognitive disorder with Lewy Bodies, abnormal posture, and chronic obstructive pulmonary disease. Resident #11 was admitted to hospice care on 12/26/25. The care plan revised 6/26/25 revealed Resident #11 had an ulceration or interference with structural integrity of layers of skin of the sacral area caused by pressure related to friction, incontinence of bowel and/or bladder, and immobility. The goal was Resident #11's pressure ulcer would not worsen through review. Interventions included administer medications as ordered, administer treatments as ordered, utilize enhanced barrier precautions, turn and reposition the resident routinely, cleanse perineal area well with each incontinence episode, and ensure special mattress (air mattress) was in place and functioning properly. The quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #11 was cognitively intact. Further review of the MDS indicated Resident #11 was dependent on staff for toileting, personal hygiene, showering, dressing, and rolling left and right. The MDS also indicated she was always incontinent of bowel and bladder. The MDS further revealed Resident #11 had a stage 4 pressure ulcer at the time of the review. There was no indication of rejection of care. Review of a physician order written on 1/20/26 for Resident #11 instructed staff to clean her sacral wound every day shift (7:00AM to 7:00PM) with normal saline, pat dry, place calcium alginate (highly absorbent wound dressing) to wound bed, and cover with bordered dressing. Review of Resident #11's wound flow sheet dated 5/9/26 stated the sacral wound measured 2 centimeters (cm) x 0.8cm x 0.7cm. There was no tunneling (a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound), undermining (destruction of tissue or ulceration extending under the skin edges), or odor present. The wound was noted to have a scant amount of serous (thin, watery, clear) drainage present, and it was described as having 75% to 100% beefy red granulation tissue (pink-red moist tissue that fills an open wound, when it starts to heal). Review of Resident #11's Treatment Administration Record (TAR) for May 2026 revealed the sacral wound treatment was not documented as completed on 5/10/26 and 5/11/26. An observation Nurse #6 providing wound care for Resident #11 was completed on 5/12/26 at 11:30 am and revealed a pressure wound to the sacrum, with beefy red granulation tissue. The observation further revealed the dressing was dated 5/9/26 and Nurse #6 stated the old dressing was dated 5/9/26 as he removed it. There was no odor noted. There was no active drainage to the wound bed, and the old dressing had scant yellow drainage noted. Nurse #6 completed the wound care and dressing change per the physician's order. An interview was conducted on 5/13/26 at 10:45AM with Nurse #7. She stated she worked with Resident #11 on 5/10/26 and 5/11/26. Nurse #7 revealed that she should have completed the dressing changes to the resident's sacral wound but stated she did not complete the wound care and dressing change because she was busy those days and missed them when going through her tasks on the TAR. Nurse #7 apologized and said that she had completed the resident's sacral dressing change on May 9th but understood it was supposed to be a daily dressing change. Nurse #7 stated she needed to do a better job looking at the TAR, so she would not miss dressing changes in the future. Review of Resident #11's wound flow sheet dated 5/13/26 revealed she had a stage 4 pressure ulcer to the sacrum, which measured 2 cm x 0.8 cm x 0.7 cm. An interview with the Wound Care Nurse on 5/13/26 at 11:00AM revealed that she was new to her role and had completed Resident #11's sacral wound dressing change for the first time that morning. The Wound Care Nurse stated Resident #11's sacral wound was with 100% granulated tissue and stated it measured much smaller in size than it had been previously documented in the prior months. She said there was no indication of infection noted. An (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview was conducted on 5/14/26 4:46PM with the Director of Nursing (DON). The DON was not aware Resident #11's pressure wound treatment had not been completed on 5/10/26 and 5/11/26. The DON stated her expectation would be for all treatments to be administered according to physician's order and stated it was not acceptable to not complete the dressing change, no matter the reason. An interview was conducted with the Administrator on 5/14/26 at 5:15PM. The Administrator was not aware that Resident #11's sacral wound dressing change hadn't been completed on 5/10/26 and 5/11/26. The Administrator stated his expectation would be that all treatments were completed as ordered.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interviews, the facility failed to label an in-use insulin pen with the opened and expiration date information for 1 of 4 medication carts (200-hall medication cart). The findings included: An observation was conducted of the 200-hall medication cart with Nurse #5 on 5/14/26 at 12:47 PM. The observation revealed one opened and in use Lantus Solostar insulin pen not labeled with an opened or expiration date. The insulin pen was stored in a clear zippered bag labeled with the resident's name and prescribing information. Nurse #5 was interviewed during the cart observation and stated insulin pens were supposed to be dated with the date they were opened. She further stated insulin pens should be discarded 28 days after being opened. Nurse #5 stated she was unsure when the Lantus insulin pen was opened or why the insulin pen was not dated. On 5/14/26 at 3:47 PM the Director of Nursing (DON) was interviewed and stated she expected nursing staff to label insulin pens with the date they were opened and discard them 28 days after the opened date. The Administration was interviewed on 5/14/26 at 3:48 PM and stated he expected staff to label and date medications when opened.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident, staff, Dietary Manager, and Registered Dietitian (RD) interviews, the facility failed to provide food that accommodated a documented allergy to pineapple for 1 of 4 residents reviewed for nutrition (Resident #61). Findings included: Resident #61 was admitted to the facility on [DATE]. Resident #61's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was cognitively intact with no behaviors. Resident #61's electronic health record revealed an undated area on the clinical dashboard listed food allergies as pineapple and tree nuts and listed the severity as unknown. A review of Resident #61's care plan document which was last reviewed on 3/9/26, stated at the bottom of the document, the resident's food allergies included pineapple and tree nuts. There was no separate care plan for the allergy. A review of a history and physical note written by the Internal Medicine Nurse Practitioner, dated 4/10/26 indicated Resident #61 had documented food allergy of pineapple with the reaction of abdominal pain. The menu posted in the dining room on 5/14/26 showed the dessert for lunch to be pineapple upside-down cake. A lunch tray observation was conducted with Resident #61 on 5/14/26 at 1:00 PM. Resident #61 was sitting in the dining area with her meal tray. Her meal tray ticket stated allergy to pineapple and tree nuts. Resident #61 was eating a piece of cake with pineapple topping. The resident stated, I don't know what is on this cake, so I am a little hesitant to eat it because I have allergies. The State surveyor intervened and alerted Nurse #7 who then removed the dessert from Resident #61's tray. Nurse #7 informed resident #61 the cake contained pineapple and asked the resident if she felt okay. Resident #61 stated she felt fine and she could not remember what happened when she ate pineapple as it had been too long ago since she last had it, but she thought it upset her stomach. On 5/14/26 at 1:05PM an observation and interview was conducted with Nurse #7. She was obtaining Resident #61's vital signs and stated she had telephoned the facility provider who gave her a verbal order to administer Benadryl 25mg capsule immediately and then every 8 hours as needed for allergic reaction for Resident #61 which she stated she had administered. An observation was made in the dining room on 5/14/26 at 1:10PM when Nurse #7 asked the three Nurse Aides (NAs) who helped serve the meal trays for that lunch meal and if any of them had served Resident #61 the cake. All three NAs (NA #3, #5, and #6) denied serving Resident #61 the cake. Nurse #7 told the three NAs the cake contained pineapple and Resident #61 was allergic to pineapple. Nurse #7 told the NAs they needed to read the resident's dietary tickets before serving them their food. During an interview with the Dietary Manager on 5/14/26 at 1:15PM he revealed he expected all staff who handed out meal trays to read each resident's dietary ticket to be made aware of any allergies or food preferences. The Dietary Manager stated the kitchen sent out the desserts for the dining room on a separate tray and it was up to the staff handing the desserts out to look at the dietary tickets before giving them to the residents. An interview was conducted with the RD on 5/14/26 at 1:20PM and she stated it would have been the responsibility of the NAs to read the dietary tickets and give the residents the correct desserts. During an interview with the Director of Nursing (DON) in the presence of the Administrator on 5/14/26 at 1:57PM, the DON stated she had been made aware that Resident #61 was given pineapple during lunch and that she had since spoken to all staff members present regarding food allergies and the importance of reading the dietary tickets.		

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interviews with staff, the facility failed to ensure the medical record was complete regarding documentation of wound care for 1 of 3 residents reviewed for pressure ulcers (Resident # 11).The findings included:Review of Resident #11's Treatment Administration Record (TAR) revealed that in March 2026, nurse's initials were missing for the sacral dressing change order on March 1st, 4th, 5th, 11th, 15th, 20th, 21st, and 22nd.Review of the TAR for April 2026 for Resident #11, revealed it was missing nurse's initials for the sacral dressing change on April 4th, 5th, 12th, 18th, 19th, and 21st.Review of Resident 11's TAR for May 2026 revealed it was missing nurse's initials on May 2nd, 3rd, 4th, 6th, 7th, 10th, and 11th.An interview was conducted with Nurse #6 on 3/13/26 at 3:30PM. He stated that he worked on May 3rd, 4th, and 7th, and stated that he completed the dressing changes for Resident #11 on those days. Nurse #6 stated that he was very busy on those days and did all the medications and treatments. Nurse #6 reported he got too busy at times to get everything charted. Nurse #6 further stated on April 5th, 2026, and March 15th and 22nd, 2026 he was certain he completed the sacral dressing changes for Resident #11. He explained he knew he completed the dressing changes because when he worked he ?always completed all of his work'. Nurse #6 reported he must have been too busy on those dates to sign the TAR. On 5/14/26 at 11:19AM, a telephone interview was conducted with Nurse #8. She stated she was familiar with Resident #11 but no longer worked for the facility. Nurse #8 stated that if she was scheduled to work, she knew she would have completed the wound care for Resident #11 because she ?always did her work'. Specifically, regarding her missing initials for March 4th, 5th, 11th and 20th, 2026 Nurse #8 stated she was sure she completed the dressing changes and probably just forgot to sign the TAR on those days. A telephone interview was conducted on 5/14/26 at 12:21PM with Nurse #10. She revealed she worked on April 12th, 2026, with Resident #11 and stated that another nurse (Nurse #12) completed the sacral dressing change for Resident #11 that day because Nurse #12 had the required supplies to complete the dressing change.An interview with Nurse #1 on 5/14/26 at 1:00PM revealed that she remembered working with Resident #11, on April 19th and May 2nd, 2026, but stated that another nurse (Nurse #11) split the shift with her and Nurse #11 was the nurse who completed the sacral dressing changes for both of those dates. Nurse #1stated that she worked from 7:00AM to 3:00PM and then Nurse #11 worked from 3:00PM to 7:00PMDuring a telephone interview conducted on 5/14/26 at 1:41PM, Nurse #11 stated that on April 19th and May 2nd of 2026 she remembered completing the sacral dressing changes for Resident #11. She said it was very busy and she missed getting them signed off on the TAR.During a telephone interview with Nurse #12 on 5/14/26 at 2:04PM, she stated that she may have completed Resident #11's dressing change for Nurse #10, because she commonly does other nurses dressing changes, but stated she doesn't usually sign the TAR herself when the task was not assigned to her. Nurse #12 further explained that occasionally she completed dressing changes for other nurses but stated she was busy with her own stuff too. Nurse #12 indicated she would normally tell the nurse who was assigned the dressing change that it was completed, and she would have expected that nurse to sign the TAR. Nurse #12 stated she could not recall the specifics of the date of April 12th, 2026, because she works 120 to 130 hours per week and can't remember what she did last week. Nurse #12 stated, I probably did, but I can't say for sure. Multiple attempts were made during the investigation to interview Nurse #9, but she did not return the call and no longer works for the facility. The dates Nurse #9 worked that were missing her initials in Resident #11's TAR included March 21st and April 4th and 18th, 2026.An interview was conducted with the Director of Nursing (DON) on 5/14/26 at 4:46PM. She stated that if a nurse completed a dressing change, then it was expected that they would have documented the completion in the TAR. The DON stated it was not acceptable to leave the TAR blank, and they needed to be consistently documenting their tasks. An interview was conducted with the Administrator on 5/14/26 at 5:15PM. He stated he would expect all staff to document properly.		