| - | D HUMAN SERVICES | | | | | APPROVED |
|--|---|--|---|--|---|---|
| RS FOR MEDICARE & I | MEDICAID SERVICES | | | | OMB NC | <u>. 0938-0391</u> |
| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · , | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY LETED |
| | 34G006 | B. WING _ | | | 05/ | 15/2018 |
| ROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | | |
| EEK | | | 58 | 40 GREENWOOD AVENUE | | |
| | | | L | A GRANGE, NC 28551 | | |
| (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | x | | | (X5) COMPLETION DATE |
| CFR(s): 483.430(e)(1 The facility must provinitial and continuing temployee to perform |) ide each employee with raining that enables the his or her duties effectively, | W 1 | 189 | | | |
| Based on observation review, the facility fail sufficiently trained to efficiently. This affecte (#50). The finding is: | ns, interviews and document ed to ensure staff were perform their duties ed 1 of 13 audit clients | | | | | |
| #50's dental hygiene Review on 5/15/18 of dated 11/3/17 and 12 hygiene- poor reco times daily." Further of teeth cleaning reve the client had his teet | care. client #50's dental report '9/16 revealed, "Oral mmendation to brush three review of client #50's record aled only the following days h brushed three times a day | | | | | |
| - | | | | | | |
| three times a day. During an interview of staff revealed the char staff documentation. PHYSICIAN SERVIC CFR(s): 483.460(a)(3 | n 5/15/18, the management rge person should review ES)(iii) | | 326 | | | (X6) DATE |
| | RS FOR MEDICARE & I OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER REEK STAFF TRAINING PF CFR(s): 483.430(e)(1 The facility must provi initial and continuing t employee to perform efficiently, and compe This STANDARD is m Based on observation review, the facility fails sufficiently. This affected (#50). The finding is: Staff was not sufficient #50's dental hygiene of Review on 5/15/18 of dated 11/3/17 and 12/ hygiene- poor recond times daily." Further no of teeth cleaning revers the client had his teeth for the last three mont 5/10/18 4/11/18 4/11/18 During an interview of client #50's tooth brust three times a day. During an interview of staff documentation. PHYSICIAN SERVICU CFR(s): 483.460(a)(3 | RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES FORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006 PROVIDER OR SUPPLIER REEK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure staff were sufficiently. This affected 1 of 13 audit clients (#50). The finding is: Staff was not sufficiently trained concerning client #50's dental hygiene care. Review on 5/15/18 of client #50's dental report dated 11/3/17 and 12/9/16 revealed, "Oral hygiene- poor recommendation to brush three times daily." Further review of client #50's record of teeth cleaning revealed only the following days the client had his teeth brushed three times a day for the last three months: 5/10/18 4/11/18 5/10/18 4/11/18 During an interview on 5/15/18, staff revealed client #50's tooth brushing should be completed three times a day. During an interview on 5/15/18, the management staff documentation. PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii) | RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: (X2) MULT A. BUILDI 34G006 B. WING | RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE A. BUILDING_ 34G006 B. WING | STOR MEDICARE & MEDICAID SERVICES OF DEFINICIENCIES (11) PROVIDER/OUPPLICACUA DEPUTIFICATION NUMBER: (22) MULTIPLE CONSTRUCTION A BUILDING 34G006 B. WING REVIDER NUMPLIER STREET ADDRESS, CITY, STATE, ZIP CODE Set GREENWOOD AVENUE LA GRANGE, NC 28551 REEK STREET ADDRESS, CITY, STATE, ZIP CODE Set GREENWOOD AVENUE LA GRANGE, NC 28551 SUMMARY STREMENT OF DEPICIENCES (EACH DEPICIENCY RUST BE PRECIDED BY FULL REGULATORY OR USE DEMITIVING INFORMATION) PROVIDERS PLANOF CORRECTION (EACH COMPACTIVE ACTION SHOLD BE PROVIDERS PLANOF CORRECTIVE ACTION SHOLD B CROSS REFRENCE ACTION SHOLD B (EACH COMPACTIVE ACTION SHOLD B CROSS REFRENCE) STAFF TRAINING PROGRAM (CFR(s): 483.430(e)(1) W 189 This STAINDARD is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure staff were sufficiently. Trained to perform their duties efficiently. Traine of Deprotem their duties efficiently. Trained to perform their duties efficiently. Trained to 13 audit clients (#50). The finding is: Staff was not sufficiently trained concerning client #50's dental hygiene care. Review on 5/15/18 of client #50's dental report date 11/3/17 and 12/9/16 revealed. "Oral hygiene-poor recommendation to brush three times daily." Further review of client #50's tecord of techt cleaning revealed only the following days the client hab is techt brushed three times a day for the last three months: 5/10/18 4/11/18 During an interview on 5/15/18, thermangement staff revealed the charge person should review staff documentation. PHYSICLANS ERVICES CFR(s): 483.460(a)(3)(iii) | SS FOR MEDICARE & MEDICAID SERVICES OMB INC OF DERCENCES (x) PROVIDERSUPLIERCIA LIBENTIFICATION (x) MULTIFILE CONSTRUCTION A. BUILINIG (x) DUICE COMP STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE (x) DUICE STREET ADDRESS, CITY, STATE, ZIP CODE WONDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE (x) DUICE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STREMENT OF DEFICIENCIES In REGULATORY OR ISC DERTIFYING INFORMATION) PERVIDERS, VALOE CORRECTION (CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY MUST REPROCEED DY FULL REGULATORY OR ISC DERTIFYING INFORMATION) PERVIDERS, VALOE CORRECTION (CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY MUST REPROCEED BY FULL REGULATORY OR ISC DERTIFYING INFORMATION) PERVIDE STAFF TRAINING PROGRAM (CFRQ); 483,430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or the duites effectively, efficiently, and competently. W 189 This STANDARD is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure staff were sufficiently trained to perform his or the duites efficiently. This affected 1 of 13 audit clients (#50). The finding is: Staff was not sufficiently trained concerning client #50's dental hygiene care. Review on 5/15/18 of client #50's dental report dated 11/3/17 and 12/9/16 revealed, Oral hygiene-poor recommendation to hash three times aday. Strift as of leint #60's booth brushing should be completed three times a day. During an interview on 5/15/18, the manag |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

PRINTED: 05/21/2018

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 05/21/2018 APPROVED . 0938-0391 | |
|------------------------------------|---|--|--|---|---|-------------------------------|---|--|
| STATEMENT OF DEFICIENCIES (X1) PRO | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
| | | 34G006 | B. WING | | _ | 05/15/2018 | | |
| NAME OF PF | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | ATE, ZIP CODE | | | |
| BEAR CRI | EEK | | | 840 GREENWOOD AVENU A GRANGE, NC 28551 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | B PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| W 326 | Continued From page | 9 1 | W 326 | | | | | |
| | • • | ide or obtain annual physical client that at a minimum es when needed. | | | | | | |
| | Based on record revi failed to ensure a con | not met as evidenced by: ew and interview, the facility sultation with the physician ended for 1 of 13 audit ding is: | | | | | | |
| | Client #50 did not retu recommended. | urn to physician as | | | | | | |
| | a hearing evaluation of | client #50's record revealed dated 2/16/12 which stated, nplificationfollow-up with | | | | | | |
| W 368 | | ΓΙΟΝ | W 368 | | | | | |
| | | administration must assure iinistered in compliance with s. | | | | | | |
| | Based on record revi facility's drug adminis | not met as evidenced by: ew and interviews, the tration system failed to administered in compliance s. The findings are: | | | | | | |
| | The facility's Incident | Report Records showed a | | | | | | |

Facility ID: 922017

If continuation sheet Page 2 of 7

| | | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | D: 05/21/2018 MAPPROVED D. 0938-0391 |
|--------------------------|--|--|-------------------|--|---|------|--|
| | | DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY PLETED |
| | | 34G006 | B. WING | | | 05/ | 15/2018 |
| NAME OF PR | ROVIDER OR SUPPLIER | | • | S | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| | | | | 5 | 840 GREENWOOD AVENUE | | |
| BEAR CRI | EEK | | | L | A GRANGE, NC 28551 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| W 368 | Continued From page | | w | 368 | | | |
| | pattern of medication pharmacy. | errors involving the | | | | | |
| | reports showed a staf 29/17 regarding a clie | B of the facility's incident If medication error on 5/24 - ent receiving a wrong dose computer being out of | | | | | |
| | reports showed a mee | 1/18 and a client's missed | | | | | |
| | the time period of 5/24 | the physician's orders for 4/17 - 4/1/18 of the pattern isted on the incident reports ysician's orders. | | | | | |
| | nursing (DON) reveal incidents; however, th | n 5/15/18, the director of ed she was aware of the 2 he facility had not developed se occurrence in the future. | | | | | |
| | executive director rev staff's medication error confirmed staff medic 6/30/16, 7/18/16, 8/17 11/24/16 and 3/1/17. with the executive dire medication trained an training with the nurse executive director cor | e upon initial hire. The nfirmed aside from | | | | | |
| | in a medication error of corrective supervision | oon initial hire, staff involved receive one on one of which is conducted by and no formal training is | | | | | |

Facility ID: 922017

If continuation sheet Page 3 of 7

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 05/21/2018 APPROVED . 0938-0391 |
|---|---|---|---------------------|---|--|------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | · · / | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | |
| | | 34G006 | B. WING | | _ | 05/1 | 15/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STA | | | |
| BEAR CR | EEK | | | 340 GREENWOOD AVENU A GRANGE, NC 28551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| W 368 | Continued From page | e 3 | W 368 | | | | |
| W 369 | and the qualified intel professional (QIDP), I following: 1). There h medication errors; 2). due to high staff turno initial medication adm hires then the lead sta corrective supervision thereafter; 4). The lead any formal staff trainin only one on one correct review of new hire medication errors in the errors need further ex DRUG ADMINISTRAT CFR(s): 483.460(k)(2) The system for drug a that all drugs, includin self-administered, arect This STANDARD is n Based on observation interview, the facility f medications were adr of 13 audit clients (#2) Client #27's medication without error. During dinner observation the table consuming f | both confirmed the has been a pattern of staff Medication errors may be over; 3). The nurse provides hinistration teaching to new aff provides the one on one in on medication errors ad staff does not provide ings on medication errors - ective supervision which is a edication administration is concern regarding he home; 6). Medication kamination. TION 2) administration must assure ing those that are e administered without error. | W 369 | | | | |

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | FOR | D: 05/21/2018 MAPPROVED O. 0938-0391 |
|--------------------------|---|---|---------------------|--|---------------------------------|--|
| | | ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | |
| | | 34G006 | B. WING | | 05 | 6/15/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | ST | REET ADDRESS, CITY, STATE, ZIP CO | • | |
| BEAR CR | EEK | | | 40 GREENWOOD AVENUE GRANGE, NC 28551 | | |
| (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 ((EACH CORRECTIVE ACTI) CROSS-REFERENCED TO TH DEFICIENC' | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| W 369 | container without stirr proceeded on to adm seated next to client # client #27 asked the r was emptied into clier medication technician The staff member the beverage mixture, ber consuming her bevera medication technician medication technician medication room. Additional observation #27 consumed part of approximately 1/4th of in her container. During an immediate 5:56pm on 5/14/18 wi revealed client #27 re beverage and this is of administration. Further revealed she did not r client #27 consumed because she only new Review on 5/15/18 of orders dated 5/11/18 to revealed "Diet: Low c dietBenecalorie bid. Review on 5/15/18 of program plan (IPP) da dietitian review indica continue with current provide Benecalorie bid. | r into client #27's beverage ing and then promptly inister medication to a client #27. Then, staff assisting medication technician what at #27's beverage and the a informed the staff member. In stirred up client #27's gan assisting client #27 with age mixture while the a promptly returned to the a promptly returned to the a son 5/14/18 revealed client f her beverage resulting in of the beverage mixture left interview at approximately ith the medication technician beeives Benecalorie in her ordered for 5pm er, the medication technician heed to remain to ensure all of the beverage mixture eds to "monitor acceptance." client #27's physician o 5/31/18 last signed 4/19/18 holesterol, minced ." client #27's individual ated 10/4/17 revealed a ting "[client #27] should plan, except suggest to to oid. Benecalorie can be be or puddings or fruit juice. | W 369 | | | |

| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | : 05/21/2018 APPROVED . 0938-0391 |
|---|--|--|--|---|---|-------------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
| | | 34G006 | B. WING | | _ | 05/* | 15/2018 |
| NAME OF PI | ROVIDER OR SUPPLIER | | S | TREET ADDRESS, CITY, ST | TATE, ZIP CODE | - | |
| BEAR CR | EEK | | | 840 GREENWOOD AVENU A GRANGE, NC 28551 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORREC CROSS-REFEREN | S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| W 369 | Continued From page | 3 5 | W 369 | | | | |
| W 455 | nursing (DON) confirm technician should haw #27 consumed all the Benecalorie. In addition medication technician the medications are a INFECTION CONTRO CFR(s): 483.470(I)(1) There must be an act prevention, control, and and communicable di This STANDARD is r Based on observation failed to ensure infect procedures were carr affected all clients rest finding is: Precautions were not health and prevent po During evening obser 5/14/18 at approximat trash container. Furth while they picked it up inside of the trash cor position and then provice client's cup, bowl and staff wash their hands | ve remained to ensure client a beverage mixed with on, the DON confirmed as are trained to ensure all of administered as ordered. DL ive program for the nd investigation of infection seases. not met as evidenced by: ns and interviews, the facility tion control prevention ied out. This potentially siding in the facility. The taken to promote client ossible cross-contamination. vations in the facility on tely 6pm, staff picked up a her observations revealed o, their hands touched the ntainer. After a client anted food, the staff ntainer back to its floor ceeded to touch another spoon. At no time did the | W 455 | | | | |

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| | - | ID HUMAN SERVICES MEDICAID SERVICES | | | | FORM | 05/21/2018 APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|---|--|------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES CORRECTION | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | BURVEY ETED |
| | | 34G006 | B. WING | | | 05/1 | 5/2018 |
| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, S | | | |
| BEAR CR | EEK | | | 5840 GREENWOOD AVEN LA GRANGE, NC 2855 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH CORRE CROSS-REFERE | S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| W 455 | 5/14/18 at approxima picked up a trash com revealed when staff p their hands touched t container. After a clie unwanted food into a staff held, the same s container back to its f to open a cooler, take applesauce and prese Additional observation propelling the wheelc dining room table. At their hands. During an interview o staff should have was touching the trash. During an interview o intellectual disabilities confirmed staff should their hands become of also revealed there a located on the walls of | tely 6:13pm, another staff tainer. Further observations picked up the trash container, he inside area of the trash ent disposed of their trash container of which staff returned the trash floor position and proceeded e out 2 containers with ent them to a client. Ins revealed the staff hair of another client to the t no time did the staff wash n 5/15/18, staff revealed shed their hands after n 5/15/18, the qualified | W 455 | | | | |

Facility ID: 922017

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