DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G006	A. BUILDING _____ B. WING _____	05/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR CREEK	5840 GREENWOOD AVENUE LA GRANGE, NC 28551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 189	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 trained to perform their duties 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 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 4/17/18 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 revealed the charge person should review staff documentation.	W 189	DHSR - Mental Health JUN 01 2018 Lic. & Cert. Section Team to meet 5/30/18 to determine more aggressive ways to improve oral health. Staff will be inserviced on plans that are established in the meeting. Monitoring for toothbrushing and data collection to occur weekly by QP, Unit Supervisor, Unit Charge, and/or HS.	7/14/18
W 326	PHYSICIAN SERVICES CFR(s): 483.460(a)(3)(iii)	W 326		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ruane Davis
TITLE: Administrator
(X6) DATE: 5/29/18

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.

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W 326	Continued From page 1	W 326		
	The facility must provide or obtain annual physical examinations of each client that at a minimum includes special studies when needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a consultation with the physician occurred as recommended for 1 of 13 audit clients (#50). The finding is: Client #50 did not return to physician as recommended. Review on 5/15/18 of client #50's record revealed a hearing evaluation dated 2/16/12 which stated, "...Will not tolerate amplification...follow-up with McCall." During an interview on 5/15/18, the director of nursing (DON) revealed client #50 should have been followed up as recommended.		Audiological appointment is scheduled for 6/6/18. Nurses will be inserviced to not make any additions to consultations. DON will review consultations following doctor's appointments to ensure adequate follow up occurs. QPs and Nurses will be re-inserviced on thoroughness of completion of QP reviews and Medical Record Audits. Formal monitoring to occur through quarterly Medical Record Audits.	7/14/18
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility's drug administration system failed to ensure all drugs were administered in compliance with physician's orders. The findings are: The facility's Incident Report Records showed a	W 368		

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W 368	Continued From page 2 pattern of medication errors involving the pharmacy. a. Review on 5/15/18 of the facility's incident reports showed a staff medication error on 5/24 - 29/17 regarding a client receiving a wrong dose due to the pharmacy computer being out of service. b. Review on 5/15/18 of the facility's incident reports showed a medication error due to a pharmacy entry on 4/1/18 and a client's missed doses of Valium on 4/1 - 2/18. Review on 5/15/18 of the physician's orders for the time period of 5/24/17 - 4/1/18 of the pattern of medication errors listed on the incident reports showed all current physician's orders. During an interview on 5/15/18, the director of nursing (DON) revealed she was aware of the 2 incidents; however, the facility had not developed a plan to prevent these occurrence in the future. During interview on 5/15/18, the surveyor and the executive director reviewed all incident reports of staff's medication errors. The executive director confirmed staff medication errors on 5/15/16, 6/30/16, 7/18/16, 8/17/16, 8/31/16, 10/25/16, 11/24/16 and 3/1/17. Further interview on 5/15/17 with the executive director confirmed all staff are medication trained and receive medication training with the nurse upon initial hire. The executive director confirmed aside from medication training upon initial hire, staff involved in a medication error receive one on one corrective supervision of which is conducted by lead staff in the home and no formal training is completed.	W 368	Nurses will be inserviced on medications that are added to EMAR system when Pharmacy computers are down. Orders will be verified by two nurses. DON will be notified of any drug orders placed on the EMAR system by nursing. DON will then verify the order on the EMAR system. Pharmacy was contacted also. Policy has been made by the pharmacy to include a MAR review with each control substance renewal to ensure all doses can be administered at the correct times.	7/14/18

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W 368	Continued From page 3	W 368		
	During interviews on 5/15/17 with the lead staff and the qualified intellectual disabilities professional (QIDP), both confirmed the following: 1). There has been a pattern of staff medication errors; 2). Medication errors may be due to high staff turnover; 3). The nurse provides initial medication administration teaching to new hires then the lead staff provides the one on one corrective supervision on medication errors thereafter; 4). The lead staff does not provide any formal staff trainings on medication errors - only one on one corrective supervision which is a review of new hire medication administration instruction; 5). There is concern regarding medication errors in the home; 6). Medication errors need further examination.			
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all medications were administered without error for 1 of 13 audit clients (#27). The finding is: Client #27's medication was not administered without error. During dinner observations on 5/14/18 at approximately 5:48pm, client #27 was seated at the table consuming her meal and the medication technician emptied a white liquid-like substance	W 369	Clarification order received on 5/17/18 such that Benecalorie can be administered by non-medical staff. Benecalorie is now on individuals' mealcards. Staff will be inserviced on this process. Informal monitoring to occur during daily observations by QP, Unit Supervisor, and/or HS. Formal monitoring through completion of Mealtime Assessments once a week by QP, Unit Supervisor, Unit Charge, and/or HS.	7/14/18

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W 369	Continued From page 4	W 369		

from a small container into client #27's beverage container without stirring and then promptly proceeded on to administer medication to a client seated next to client #27. Then, staff assisting client #27 asked the medication technician what was emptied into client #27's beverage and the medication technician informed the staff member. The staff member then stirred up client #27's beverage mixture, began assisting client #27 with consuming her beverage mixture while the medication technician promptly returned to the medication room.

Additional observations on 5/14/18 revealed client #27 consumed part of her beverage resulting in approximately 1/4th of the beverage mixture left in her container.

During an immediate interview at approximately 5:56pm on 5/14/18 with the medication technician revealed client #27 receives Benecalorie in her beverage and this is ordered for 5pm administration. Further, the medication technician revealed she did not need to remain to ensure client #27 consumed all of the beverage mixture because she only needs to "monitor acceptance."

Review on 5/15/18 of client #27's physician orders dated 5/1/18 to 5/31/18 last signed 4/19/18 revealed "Diet: Low cholesterol, minced diet...Benecalorie bid."

Review on 5/15/18 of client #27's individual program plan (IPP) dated 10/4/17 revealed a dietitian review indicating "...[client #27] should continue with current plan, except suggest to to provide Benecalorie bid. Benecalorie can be mixed with applesauce or puddings or fruit juice. It should be administered by nursing."

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W 369	Continued From page 5	W 369		
W 455	During an interview on 5/15/18, the director of nursing (DON) confirmed the medication technician should have remained to ensure client #27 consumed all the beverage mixed with Benecalorie. In addition, the DON confirmed medication technicians are trained to ensure all of the medications are administered as ordered. INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control prevention procedures were carried out. This potentially affected all clients residing in the facility. The finding is: Precautions were not taken to promote client health and prevent possible cross-contamination. During evening observations in the facility on 5/14/18 at approximately 6pm, staff picked up a trash container. Further observations revealed while they picked it up, their hands touched the inside of the trash container. After a client disposed of their unwanted food, the staff returned the trash container back to its floor position and then proceeded to touch another client's cup, bowl and spoon. At no time did the staff wash their hands. During evening observations in the facility on	W 455	Staff will be re-inserviced on Infection Control. Informal Monitoring will occur through daily observations by QP, Unit Supervisor, and/or HS. Formal monitoring to occur through Mealtime Assessments completed once a week by QP, Unit Supervisor, Unit Charge, and/or HS.	7/14/18

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W 455	Continued From page 6 5/14/18 at approximately 6:13pm, another staff picked up a trash container. Further observations revealed when staff picked up the trash container, their hands touched the inside area of the trash container. After a client disposed of their unwanted food into a trash container of which staff held, the same staff returned the trash container back to its floor position and proceeded to open a cooler, take out 2 containers with applesauce and present them to a client. Additional observations revealed the staff propelling the wheelchair of another client to the dining room table. At no time did the staff wash their hands. During an interview on 5/15/18, staff revealed staff should have washed their hands after touching the trash. During an interview on 5/15/18, the qualified intellectual disabilities professional (QIDP) confirmed staff should wash their hands anytime their hands become contaminated. The QIDP also revealed there are antiseptic dispensers located on the walls of which staff can readily access when they are unable to immediately wash their hands.	W 455		

RHA
HEALTH SERVICES, LLC

DHSR - Mental Health
JUN 01 2018
Lic. & Cert. Section

May 30, 2018

Stephanie DeGraffenreid, RN, BSN, BA
Nurse Consultant
NC Department of Health & Human Services
Division of Health Service Regulation
Mental Health & Licensure Certification
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms. DeGraffenreid,

Thank you for your recent visit to our Bear Creek Facility. Attached is our Plan of Correction for the deficiencies you noted. We look forward to seeing you soon for the follow-up.

Sincerely,

Luanne Davis,
Facility Administrator

LD/mwh

5840 Greenwood Avenue * La Grange, NC 28551
252.566.9181 Voice 252.566.2912 Fax