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
	34G351	A. BUILDING ____ B. WING ____	**02/26/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASS LAKE	**408 BASS LAKE HOLLY SPRINGS, NC 27540**

(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
E 006	Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an Emergency Preparedness (EP) plan including and based upon a community and facility-based risk assessment, utilizing an all-hazards approach. The finding is: The facility did not have an emergency plan	E 006	The following deficiency will be corrected according to the following: A. Management will complete a site-specific Hazards and Vulnerabilities Assessment for Bass Lake. The results of this assessment will be intergrated in the overall Emergency Preparedness Plan for the site. B. Based on the assessment and the neighboring evacuation facilities, management will identify evacuation locations and document location(s) in the Emergency Preparedness Plan and Quick Reference Guide. Prior to documenting location, management will confirm with location that they have availability and the capacity to support Bass lake individuals should the home need to evacuate. C. As part of the Emergency Preparedness Plan, management will implement a Crisis Communication Plan. This communication plan will outline, who is part of the crisis communication team, whom to contact, when to contact someone, and how to contact them (i.e. phone, email, walkie-talkie, etc) D. Once the Emergency Preparedness Plan has been completed and approved by the Safety Committee, all staff will receive training on the plan. E. As part of the plan, employees and consumers will participate in either a full-scale community-based exercise and/or full-scale facility based exercise. A monthly schedule will be developed to include EPP. All drills will be documented on CANC standard Disaster Drill Form. F. Residential Manage and/or Clinical Supervisor will monitor once weekly to ensure that trainings are occurring as scheduled. All Disaster Drills will be reviewed monthly a Safety Committee. G. Management will review Emergency Preparedness Plan (EPP) annually. Clinical Supervisor will revise plan annually. DHSR - Mental Health APR 02 2019 Lic. & Cert. Section	4/27/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jason Peace	Executive Director	3/25/19

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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E 006	Continued From page 1 based upon risk assessments. Review on 2/25/19 of the facility's current EP plan revealed the plan did not provide specific information in regards to a facility-based and/or community-based risk assessment using an all-hazards approach including flood, fire, tornadoes, hurricanes, winter storms, bio terrorism, missing clients, nuclear plant leak or other emergency types. Interview on 2/25/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed no EP plan risk assessment had been completed utilizing an all-hazards approach.	E 006	Please see E 006, page 1.	
E 020	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.475(b)(3) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):]	E 020	Please see E 006, page 1.	

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E 020	Continued From page 2 Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the policies and procedures included information for safe evacuation from the facility, which included identification of evacuation location(s); and primary means of communication with external sources of assistance. The finding is: The facility did not identify any places or locations for the facility to evacuate or a means of communication with the places. Review of the emergency plan (EP) on 2/25/19	E 020	Please see E 006, page 1.	

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E 020	Continued From page 3 revealed no information about where the facility should evacuate off campus if needed. It further did not reveal a means of communication nor any information about how the staff should communicate with the others when on evacuation. Interview with the facility group home manager and the qualified intellectual disability professional (QIDP) on 2/25/19 confirmed the EP did not have any disentitled locutions for the evacuation process.	E 020	Please see E 006, page 1.	
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on review of the Emergency Plan (EP) the facility failed to develop an alternate means of communicating with staff, Federal, State and other emergency management agencies. The finding is:	E 032	Please see E 006, page 1.	

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E 032	Continued From page 4 The facility failed to have a communication plan. Review of the EP on 2/25/19, revealed no communication plan to address the alternate communication methods. Interview with the Group Home Manager on 2/25/19 confirmed the facility EP did not include a communication plan. Staff interview revealed the same.	E 032		
E 036	EP Training and Testing CFR(s): 483.475(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h).	E 036	Please see E 006, page 1.	

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E 036	Continued From page 5 *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to develop an emergency preparedness (EP) training and testing program. The finding is: Management staff failed to develop a comprehensive training program for direct care staff on the facility's emergency management plan. Review on 2/25/19 of the facility's EP revealed no training of direct care staff on the facility's emergency management plan. Interview with three direct care staff on 2/25/19 revealed they had not been trained on the facility's EP. Further interview revealed staff were not consistently aware of any alternate locations to which the clients may be evacuated. Staff were also unaware of any alternate communication plan. The Group Home manager was able to identify there was a cell phone purchased for the facility; however, he stated that he carries that pone with him at all times. Staff stated they had not been trained.	E 036	Please see E 006, page 1.	

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E 036	Continued From page 6 Review on 2/25/19 with the facility's qualified intellectual disabilities professional (QIDP) revealed the facility had not provided facility wide training or testing on the emergency management plan developed by management.	E 036	Please see E 006, page 1.	
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated,	E 039	Please see E 006, page 1.	

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E 039	Continued From page 7 clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise or testing. Review on 2/25/19 of the facility's EP plan did not include a full-scale community-based or individual	E 039	Please see E 006, page 1.	

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E 039	Continued From page 8 facility-based exercise or a tabletop exercise to test their emergency plan. Neither did the EP include testing of staff. Interview on 2/25/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop exercise to test the effectiveness of their current emergency plan.	E 039	Please see E 006, page 1.	
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure the record was accurate complete. This affected 1 of 3 audit clients (#3) The finding is: Client #3's individual program plan (IPP) was not accurate. Review on 2/26.19 of client #3's IPP dated 1/20/19 revealed a date of birth of 3/29/16 and the face sheet date of birth of 9/18/55. The birth certificate matched the face sheet not the IPP. It further noted another client (client #4's) name on page 3, page 4 (in 8 places) page 5 in one place and another client (client #4's) guardian contact information and name. Page 7 of the IPP was missing and found in another part of the record. Page 7 revealed another client (client #4's) name	W 111	The noted deficiences will be corrected by the following actions: A. All Clinical Supervisors (CS) will be provided an example of an Individual Support Plan by which they should model. B. Upon completion of each ISP, the document will be forwarded to the Program Manager to review to ensure accuracy and thorough integration of assessment recommendations and needed supports. C. Clinical Supervisor will review clincal documentation bi-monthly. D. PM manager will review monthly using internal site review process.	4/27/19

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W 111	Continued From page 9 in two places. The diet listed and described in the IPP on page 8 was clearly that of Client #4's and page 9 listed client #4's adaptive dining equipment. Interview on 2/26/19 with staff reveled that much of the information listed in client #3's plan belonged to client #4. Interview on 2/26/19 with management confirmed this plan was not accurate.	W 111	Please se W 111, page 10.	
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 and interviews the facility failed to assure staff training on taking all medicasions during a medication pass. This potentially affected all clients. The finding is: Medications were not kept under lock and key at all times. During observations on 2/25/19 at 5:10pm when client #5 went to step onto the van and as she did, a pill fell from her coat pocket. Upon further observation, the dropped pill was compared to client #5's medications and determined to be a "Pepcid 20 mg pill." The Medication Administration Record (MAR) was reviewed and there was no way to determine when the pill got into her pocket.	W 189	The noted deficiences will be corrected by the following actions: A. All employees will either be assigned on-line training for medication administration and/or will be provided in-person training by the RN. Training will consist of medication administration practices that include, but not limited to: 1. Proper medication storage 2. Proper MAR documentation 3. Proper storage and security of medication (including key assignement and access) 4. Proper administration and ensuring all medication have been properly swallowed B. RN and Residential Manager will alternate weekly medication closet checks. C. Residential Manager will check MAR documentation and drug storgae daily. D. RN will check MAR documentation and drug storage weekly. E. Residential Manager and RN will ensure that medication remains properly stocked. F. Residential Manager and RN will ensure that Incident Reports and Medication Error reports are completed as required. G. Residental Manager will monitor daily. H. RN will monitor weekly. I. Clinical Supervisor will monitor monthly.	4/27/19

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W 189	Continued From page 10 Interview with the management on 2/25/19 confirmed the pill to be Pepcid and confirmed the pill should have been kept locked except when being taken and that staff should be trained to assure the pill is swallowed at each medication pass.	W 189	Please see W 189, page 10.	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview the facility failed to assure the individual program plan (IPP) for 1 of 3 audit clients was consistently implemented as written, specifically in the area of dining. This affected 1 audit client (#5). The finding is: Client #5's feeding guidelines were not consistently implemented as written. Throughout observations on 2/25-2/26/19, client #5 ate independently and was not encouraged to pause and put her utensil down and drink her beverages. Review on 2/25/19 of client #5's IPP dated	W 249	The noted deficiences will be corrected by the following actions: A. Clinical Supervisor will review all assessments and fully integrate the recommendations into the ISP. The integration of recommendations will include, but not be limited to food preparation, meal time protocols, and use of adaotive equipment. B. All adaotive equipment will be full integrated into the ISP to include type of adaptive equipment, when it is to be used, and how it is to be used. C. All staff will complete Active Treatment and Food Prep Training that will include testing. D. Residential Manager will monitor and document 3x/ week. E. Clinical Supervisor will monitor and document 2x/ weekly.	4/27/19

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W 249	Continued From page 11 10/18/18 revealed staff should encourage client #5 to put her utensil down in between bites and encourage liquid intake between each bite. Additionally, it was noted that at the end of the meal staff should check for pocketing and encourage her to swallow or take her to the restroom and removed as needed. Interview with management on 2/26/19 confirmed that the guidelines for mealtime should have been followed as written.	W 249	Please see W 249, page 11.	
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure drugs used for behavior management were not ordered on a PRN (as needed) basis for 1 of 3 audit clients (#5). The findings are: Client #5's behavior medication was ordered on a PRN basis. Review on 2/25/19 of client #5's record revealed a BSP with a protocol for agitation which incorporated the use of Clonazepam 0.5 mg (Equiv. to Klonopin) as a PRN medication. This protocol "for Agitation and PRN medication" was dated 10/18/18. Additional review of the client's	W 312	The noted deficiencies will be corrected by the following actions: A. The Clinical Supervisor will review all Behavior Support Plans to ensure that any psychotropic medication administered has both a diagnosis and targeted behavior that warrants its administration. B. This review will also be used to determine if the administration of psychotropic drug is stil appropriate based on currently displayed behaviors. C. If the current behaviors do not warrant continued administration of medication, then the Clinical Supervisor will seek to titrate the dosage where appropriate. D. Behavior Support Plans/ Guidelines will be revised to include targeted behaviors and their corresponding medications. E. HRC and consent signatures will be obtained for all revised Behvavior support plans/ strategies. F. Clinical Supervisor will monitor and document monthly.	4/27/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G351	A. BUILDING ______ B. WING ______	02/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASS LAKE	408 BASS LAKE HOLLY SPRINGS, NC 27540

(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 312	Continued From page 12 physician's orders dated 1/2/19 noted Clonazepam tab 0.5 mg "take 1 tablet by mouth twice daily as needed for agitation and prior to doctor's appointments." Interview on 2/13/19 with the Qualified Intellectual Disabilities Professional (QIDP) and Home Manager (HM) revealed client #5's PRN had been administered several times over the past several years. During an additional interview, the QIDP and HM acknowledged client #5 also has a physician's order for a PRN medication which is prescribed for behavior management. She further indicated that she was made aware from another facility survey that the facility should not have prn medications without a plan to address and decrease the use of the medication.	W 312	Please see W 312, page 12.	