

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

PRINTED: 11/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G351	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/04/2020
NAME OF PROVIDER OR SUPPLIER BASS LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000 {W 252}	<p>INITIAL COMMENTS</p> <p>A revisit was conducted on 11/4/2020, for all previous deficiencies cited on 2/19/2020. Some deficiencies have not been corrected. No new noncompliance was found. The facility is not in compliance with all regulations surveyed</p> <p>PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure all data relative to the accomplishment of objectives was documented as indicated. This affected 1 of 2 audit clients (#1). The finding is:</p> <p>A. Client #1's Physical Therapy (PT) exercises and pressure relief/positioning program were not documented as recommended.</p> <p>Review on 11/4/20 of client #1's record revealed a PT annual review dated 6/2019. The PT review included the following recommendations:</p> <p>"1. Continue exercise program. Staff should continue use of monthly exercise log to monitor [Client #1's] participation and response. 2. Continue positioning and pressure relief program. Staff should continue of use of monthly positioning/repositioning log to monitor schedule..."</p>	W 000 {W 252}			

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

TITLE

(X6) DATE

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.

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

PRINTED: 11/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G351	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/04/2020
NAME OF PROVIDER OR SUPPLIER BASS LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 252}	Continued From page 1 Review of client #1's objective training book did not include any documentation of PT exercises and a pressure relief/positioning program as recommended. Interview on 11/4/2020 with staff A reviewed client #1 body stretch exercise are performed by staff as PT guideline and no documentaion done. Interview on 11/4//20 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's PT exercises should have been collected as recommended.	{W 252}			
{W 263}	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure restrictive Behavior Support Plan for 1 of 3 audit clients (#3) was only conducted with the written informed consent of the legal guardian. The findings are: Client #3's BSP did not include written informed consent from the guardian. Review on 11/4/20 of client #3's BSP dated 1/30/2020 revealed an objective to display 0 episodes of agitation per month for 12 consecutive months. The plan identified the use of Olanzapine, Fluvoxamine, Thorazine and	{W 263}			

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

PRINTED: 11/16/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G351	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/04/2020
NAME OF PROVIDER OR SUPPLIER BASS LAKE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 263}	Continued From page 2 Phenobarbital. Further review of the record did not include a current written informed consent for the BSP from his guardian. Interview on 2/19/20 with the Qualified Intellectual Disabilities Professional (QIDP) indicated a written informed consent had been sent to client #3's guardian; however, it had not been returned.	{W 263}			