		AND HUMAN SERVICES					ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	1	3) DATE SURVEY COMPLETED
		34G006	B. WING				04/20/2021
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
BEAR CF	REEK				40 GREENWOOD AVENUE A GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 000	INITIAL COMMEN	rs	wo	000			
W 229	the recertification s There were no defi		W 2	229			
		ne individual program plan arately, in terms of a single e.					
	Based on record re facility failed to ens clients (#5 and #7)	s not met as evidenced by: eviews and interviews, the ure objectives for 2 of 9 audit were stated separately and in ehavioral outcome. The					
	Program Plan (IPP objectives, "When [Client #5] will ident how much it is wort for 3 consecutive m cue, [Client #5] will	/21 of client #5's Individual) dated 3/23/21 revealed the presented with two cues, tify the penny correctly and tell h with no errors 60% of trials nonths" and "With one verbal recognize and say the 2 or less errors 50% of trials nonths."					
	Intellectual Disabilit acknowledged the	on 4/20/21, the Qualified ies Professional (QIDP) objective statements were not a single behavioral outcome.					
	B. Review on 4/19,	/21 of client #7's IPP dated					
LABORATOR	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

(X6) DATE

PRINTED: 04/21/2021

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.

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 34G006 B. WING 04/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **5840 GREENWOOD AVENUE BEAR CREEK** LA GRANGE, NC 28551 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 229 Continued From page 1 W 229 10/6/20 revealed an objective to "...assemble six four letter words and pronounce (kite, sand, lion, mom) them with physical prompts for 85% of trials for 3 consecutive months". Interview on 4/19/21 with the QIDP and Habilitation Specialist (HS) confirmed the objective statement was not written in terms of a single behavioral outcome. NURSING SERVICES W 340 W 340 CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record and policy reviews and staff interviews, the nursing services failed to ensure that staff were sufficiently trained in medication administration policy for 2 of 9 audit clients (#8 and #9). The findings are: A. During morning observations on the Green Acres Unit on 4/20/21 at 7:42am, the licensed practical nurse (LPN #1) had several small medications cups prepared with crushed medications dissolved in water, on top of the medication cart. LPN #2 remained in the medication room, at her cart. LPN #1 approached client #8 at a table and rolled him into the medication room. LPN #1 announced to client #8 that she was pouring his medications for allergies and seizures into his gastrostomy tube (g-tube) at

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 04/21/2021

		AND HUMAN SERVICES				FORM	: 04/21/2021 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G006	B. WING			04	/20/2021
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BEAR C	REEK				340 GREENWOOD AVENUE A GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 340	Continued From pa 7:45am.	ge 2	W 3	840			
	4/20/21 from 7:13a dispensed medicati medication cart and client at a table in a sitting in their bedro prompted or encou	s in the Blue Bayou Unit on m - 7:25am, LPN #3 ions from the mobile d took the medications to a in activity area and a client bom. The clients were not raged to come to the d medications were not oresence.					
	generally does not the medication area	1 with LPN #3 indicated she move the medication cart from a and medications are usually where they are located.					
	Administration Polic	of the facility's Medication cy, dated October 2018 read dministered at the time they					
	she liked to have th	#1 on 4/20/21 revealed that he medication already set up the clients into the medication					
	(ADON) on 4/20/21 with a g-tube is sch client should be bro	ssistant director of nursing revealed that when a client eduled for medication, the bught into the medication dications should be prepared.					
	4/20/21 revealed th	irector of nursing (DON) on at medications should not be f the clients' presence.					
		observations on the Green 21 at 8:00am, LPN #1 brought					

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		AND HUMAN SERVICES			FORM	04/21/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		34G006	B. WING		04/:	20/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BEAR CI	REEK			5840 GREENWOOD AVENUE LA GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 340	client #9 into the me medications. Client LPN #1 used a stet placement of the g- medication. LPN # the following medic Prevacid into a liqu medicine cup. LPN into a syringe, conf measured a capful of water and poured The MiraLAX would #1 was observed to syringe several time would not move. LF the syringe back int plunger to draw bac syringe. LPN #1 the into the syringe in Review on 4/20/21 for Feb-April 2021, of water after AM m Review on 4/20/21 Administration via f October 2018 read, administer thirty (30 medications becaus physician. Interview on 4/20/2 LPN #1 did follow th	edication room to give #9 has a g-tube; therefore thoscope to check the tube before administering 1 had crushed and dissolved ations, Baclofen, Lamictal and id format by adding water to a I #1 then poured the medicine hected to the g-tube. LPN #1 of MiraLAX powder into a cup d the content into the syringe. d not empty the syringe. LPN o tap and gently shake the es, however the medication PN #1 emptied the contents of to a cup, then used a syringe ck the residual content into the en poured the MiraLAX back d all the medication emptied nto the g-tube. of client #9's physician orders read flush g-tube with 50cc's neds. of the facility's Medication feeding tubes policy dated , "Unclamp tube and 0) cc of water prior to	W 340			

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				NG		
		34G006	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE		/20/2021
BEAR CI	PROVIDER OR SUPPLIER			5840 GREENWOOD AVENUE LA 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
W 340	otherwise, you run causing a blockage their medication ad	before giving medications the risk of pushing in air and a. The DON acknowledged that Iministration policy hing the g-tube before and	W 34	40		
W 368	DRUG ADMINISTF CFR(s): 483.460(k) The system for dru	RATION)(1) g administration must assure dministered in compliance with	W 36	68		
	Based on observation interviews, the facil	s not met as evidenced by: tions, record review and staff lity failed to administer of 9 audit clients (#9) based on The finding is:				
	Unit on 4/20/21 at 8 nurse (LPN#1) mix into 4 ounces of wa	servations on the Green Acres 3:08am, the licensed practical ed a capful of MiraLax powder ater. The MiraLax was poured given to client #9 through a g-tube).				
	Feb-April 2021 read	's physician orders for d, Dissolve 1 capful 17gm in ce daily and give via g-tube.				
	the order was to m	1 with the LPN#1 revealed that ix the MiraLax with prune juice acknowledged that it was an				
		1 with the assistant director of vealed that the medication				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 34G006 B. WING 04/20/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5840 GREENWOOD AVENUE LA GRANGE, NC 28551 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE			AND HUMAN SERVICES					FORM	04/21/2021 APPROVED 0938-0391			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE BEAR CREEK STREET ADDRESS, CITY, STATE, ZIP CODE (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 DEFICIENCY) (X5) COMPLE DEFICIENCY								(X3) DATE SURVEY				
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) COMPLE DATE			34G006	B. WING	÷			04/2	20/2021			
BEAR CREEK 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) COMPLE DATE	NAME OF F	PROVIDER OR SUPPLIER	•	-			DDE					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DATE	BEAR C	REEK										
W 368 Continued From page 5 W 368	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD	BE	(X5) COMPLETION DATE			
should be given as written.	W 368		-	W	368							

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