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 _____	04/20/2021

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 000	INITIAL COMMENTS A complaint investigation was completed during the recertification survey on 4/19 - 4/20/21. There were no deficiencies cited as a result of the complaint survey for intakes NC00176251 and NC00176256.	W 000		
W 229	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4)(i) The objectives of the individual program plan must be stated separately, in terms of a single behavioral outcome. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure objectives for 2 of 9 audit clients (#5 and #7) were stated separately and in terms of a single behavioral outcome. The findings are: A. Review on 4/19/21 of client #5's Individual Program Plan (IPP) dated 3/23/21 revealed the objectives, "When presented with two cues, [Client #5] will identify the penny correctly and tell how much it is worth with no errors 60% of trials for 3 consecutive months" and "With one verbal cue, [Client #5] will recognize and say the alphabet A - F with 2 or less errors 50% of trials for 3 consecutive months." During an interview on 4/20/21, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged the objective statements were not written in terms of a single behavioral outcome. B. Review on 4/19/21 of client #7's IPP dated	W 229	QPs, Habilitation Specialists, and Teacher will be inserviced to ensure objectives have a single outcome. Monitoring will occur through quarterly QP reviews and preparation for annual team meeting.	5/14/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Melissa Herring | IDD Facility Administrator | 4/26/2021

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.

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W 229	Continued From page 1 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.	W 229		
W 340	NURSING SERVICES 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	W 340	Nurses and Med. Techs. will be inserviced on medication administration. Informal monitoring will occur through daily observations by DON, ADON, or Nursing Team Leaders. Formal monitoring will occur weekly through Medication Pass Audit to be completed by DON, ADON, or Nursing Team Leaders.	6/18/2021

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W 340	Continued From page 2 7:45am. During observations in the Blue Bayou Unit on 4/20/21 from 7:13am - 7:25am, LPN #3 dispensed medications from the mobile medication cart and took the medications to a client at a table in an activity area and a client sitting in their bedroom. The clients were not prompted or encouraged to come to the medication area and medications were not dispensed in their presence. Interview on 4/20/21 with LPN #3 indicated she generally does not move the medication cart from the medication area and medications are usually taken to the clients where they are located. Review on 4/20/21 of the facility's Medication Administration Policy, dated October 2018 read "Medications are administered at the time they are prepared." Interview with LPN#1 on 4/20/21 revealed that she liked to have the medication already set up before she brought the clients into the medication room. Interview with the assistant director of nursing (ADON) on 4/20/21 revealed that when a client with a g-tube is scheduled for medication, the client should be brought into the medication room, then the medications should be prepared. Interview with the director of nursing (DON) on 4/20/21 revealed that medications should not be prepared outside of the clients' presence. B. During morning observations on the Green Acres Unit on 4/20/21 at 8:00am, LPN #1 brought	W 340		

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W 340	Continued From page 3 client #9 into the medication room to give medications. Client #9 has a g-tube; therefore LPN #1 used a stethoscope to check the placement of the g-tube before administering medication. LPN #1 had crushed and dissolved the following medications, Baclofen, Lamictal and Prevacid into a liquid format by adding water to a medicine cup. LPN #1 then poured the medicine into a syringe, connected to the g-tube. LPN #1 measured a capful of MiraLAX powder into a cup of water and poured the content into the syringe. The MiraLAX would not empty the syringe. LPN #1 was observed to tap and gently shake the syringe several times, however the medication would not move. LPN #1 emptied the contents of the syringe back into a cup, then used a syringe plunger to draw back the residual content into the syringe. LPN #1 then poured the MiraLAX back into the syringe, and all the medication emptied out of the syringe into the g-tube. Review on 4/20/21 of client #9's physician orders for Feb-April 2021, read flush g-tube with 50cc's of water after AM meds. Review on 4/20/21 of the facility's Medication Administration via feeding tubes policy dated October 2018 read, "Unclamp tube and administer thirty (30) cc of water prior to medication administration." Interview on 4/20/21 with LPN #1 revealed that she did not flush the g-tube prior to administering medications because it was not ordered by the physician. Interview on 4/20/21 with the DON revealed that LPN #1 did follow the physician's order, however, as a rule of thumb, the nurse should always clear	W 340		

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W 340	Continued From page 4 or flush the g-tube before giving medications otherwise, you run the risk of pushing in air and causing a blockage. The DON acknowledged that their medication administration policy recommended flushing the g-tube before and after giving medications.	W 340		
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 observations, record review and staff interviews, the facility failed to administer medications for 1 of 9 audit clients (#9) based on physician's orders. The finding is: During morning observations on the Green Acres Unit on 4/20/21 at 8:08am, the licensed practical nurse (LPN#1) mixed a capful of MiraLax powder into 4 ounces of water. The MiraLax was poured into a syringe and given to client #9 through a gastrostomy tube (g-tube). Review of client #9's physician orders for Feb-April 2021 read, Dissolve 1 capful 17gm in 120 ml of prune juice daily and give via g-tube. Interview on 4/20/21 with the LPN#1 revealed that the order was to mix the MiraLax with prune juice and not water. She acknowledged that it was an oversight. Interview on 4/20/21 with the assistant director of nursing (ADON) revealed that the medication	W 368	Nurses and Med. Techs. will be inserviced to ensure drugs are administered according to doctor's order. Informal monitoring to occur through daily observations by DON, ADON, or Nursing Team Leaders. Formal monitoring to occur through weekly Medication Pass Audits by DON, ADON, or Nursing Team Leaders.	6/18/2021

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W 368	Continued From page 5 should be given as written.	W 368		

RHA
HEALTH SERVICES

April 26, 2021

Wilma Worsley-Diggs, M.Ed., QIDP
Facility Compliance Consultant I
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. Worsley-Diggs,

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,

Melissa Herring

Melissa Herring,
IDD Facility Administrator

mwh