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 _____	08/25/2021

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

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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 interviews, the facility failed to ensure client #5 received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of self-help skills and adaptive equipment use. This affected 1 of 3 audit clients. The findings are: A. During 3 of 3 mealtime observations in the home throughout the survey on 8/24 - 8/25/21, client #5 consumed her food using a high-sided plate, small spoon, cups with two handles and clothing protector. No other adaptive dining equipment was utilized. Interview on 8/25/21 with Staff B revealed the adaptive equipment client #5 used at meals was everything she normally uses. Review on 8/25/21 of client #5's Occupational Therapy (OT) update dated 7/9/21 indicated, "Continue with youth spoon and fork, 2 handled cup (without lid), Hi sided plate and dycem non slip mat and clothing protector."	W 249		

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

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W 249	Continued From page 1 Interview on 8/25/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #5 should be using a dycem mat at meals as indicated. B. During 3 of 3 mealtime observations in the home throughout the survey on 8/24 - 8/25/21, client #5 was not prompted or encouraged to clear her dishes after meals. Various staff completed this task without her participation. Review on 8/25/21 of client #5's IPP dated 11/23/20 revealed, "[Client #5] typically needs staff support and some hand-over-hand assistance to complete many ADL tasks." Interview on 8/25/21 with the QIDP confirmed client #5 "should be encouraged" to assist with clearing her place after meals.	W 249		
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 programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 3 audit clients (#5). The finding is: Review on 8/24/21 of client #5's Behavior Support Plan (BSP) dated 11/23/20 revealed objectives to	W 263		

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W 263	Continued From page 2 exhibit 0 episodes of inappropriate verbalizations per month for 12 consecutive months and to exhibit 1 or fewer episodes of failure to cooperate per month for 12 consecutive months. The BSP incorporated the use of Prozac, Keppra, Zyprexa and Rexulti. Additional review of the record did not include written informed consent for client #5's restrictive BSP. Interview on 8/25/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the written informed consent had been sent to client #5's guardian; however, it had not been returned as of the date of the survey.	W 263		
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 review and interviews, the facility failed to ensure the interdisciplinary team (IDT) had considered a reduction and/or elimination of restrictive behavior medications for client #5 after a decrease in target behaviors was identified. This affected 1 of 3 audit clients. The finding is: Review on 8/24/21 of client #5's Behavior Support Plan (BSP) dated 11/23/20 revealed objectives to exhibit 0 episodes of inappropriate verbalizations per month for 12 consecutive months and to	W 312		

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W 312	Continued From page 3 exhibit 1 or fewer episodes of failure to cooperate per month for 12 consecutive months. The BSP incorporated the use of Prozac, Keppra, Zyprexa and Rexulti. Additional review of client #5's physician's orders dated 7/15/21 revealed the client ingests Prozac 20mg twice daily, Keppra 500mg twice daily, Zyprexa 3mg twice daily and Rexulti 2mg at bedtime. Further review of BSP progress notes dated May '20 - July '21 revealed zero documented target behaviors for client #5. Additional review of the progress notes and the record did not indicate the IDT had considered a reduction and/or elimination of the behavior medications based on the absence of target behaviors. Interview on 8/25/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the IDT had not considered a reduction or elimination of behavior medications for client #5 based on her decrease in behaviors over the last 13 months.	W 312		
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 observation, record review and interviews, the facility failed to ensure staff were sufficiently trained on appropriate medication administration methods. This affected 1 of 3	W 340		

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W 340	Continued From page 4 clients (#3) observed receiving medications. The finding is: During observations of medication administration in the home on 8/25/21 at 6:55am, Staff C obtained a large bowled spoon from the kitchen and used it to scoop one spoonful of Metamucil powder from the container. The staff poured the powder into a cup of water and gave it to client #3 to drink with his medications. Interview on 8/25/21 with Staff C revealed they had been trained to use a kitchen spoon to dispense client #3's Metamucil. Review on 8/25/21 of client #3's physician's orders signed 6/20/21 revealed an order for "Metamucil powder 58.6%, stir 1 tablespoon well into a cup of pulp free orange (or other juice) and drink by mouth once daily...7:00". Interview via phone on 8/25/21 with the facility's nurse revealed staff have been trained to use a marked pill cup or a marked tablespoon commonly used for measuring in the kitchen to obtain the appropriate amount of Metamucil powder. The nurse indicated a kitchen spoon used for eating should not be utilized and that's a "No, No".	W 340		
W 362	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by:	W 362		

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W 362	Continued From page 5 Based on record review and interviews, the facility failed to ensure pharmacy reviews for 3 of 3 audit clients (#2, #3 and #5) included sufficient information regarding each client's drug regime. The findings are: Review on 8/24/21 of records for client #2, client #3 and client #5 revealed pharmacy reviews dated 9/11/20, 3/4/21 and 6/7/21, respectively. Each documented pharmacy review indicated the following: "MRR note on file" along with a signature. No other information was included. Interviews on 8/25/21 with the facility's nurse, the Qualified Intellectual Disabilities Professional (QIDP) and the Program Manager revealed they were not sure what was meant by "MRR note on file", where to find this note or what this note would include regarding each client's drug regime.	W 362		
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 interviews, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 1 of 3 clients (#3) observed receiving medications. The finding is: During observations of medication administration in the home on 8/25/21 at 6:55am, Staff C	W 368		

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W 368	Continued From page 6 obtained a large bowled spoon from the kitchen and used it to scoop one spoonful of Metamucil powder from the container. The staff poured the powder into a cup of water and gave it to client #3 to drink with his medications. Interview on 8/25/21 with Staff C revealed they can give client #3 his Metamucil with water or juice. Review on 8/25/21 of client #3's physician's orders signed 6/20/21 revealed an order for "Metamucil powder 58.6%, stir 1 tablespoon well into a cup of pulp free orange (or other juice) and drink by mouth once daily...7:00". Interview via phone on 8/25/21 with the facility's nurse confirmed client #3's Metamucil powder should be administered with juice as indicated on the physician's order.	W 368		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all medications remained locked except when being administered. The finding is: During observations of medication administration in the home on 8/25/21 at 7:04am, Staff C exited the medication room leaving the door to the medication closet open. During additional observations of medication administration on	W 382		

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W 382	Continued From page 7 8/25/21 at 7:17am, Staff C exited the medication area leaving a bin containing drugs on a desk in the room. A client was also observed in the medication room as the staff left the area. Interview on 8/25/21 with Staff C revealed they had been trained to lock medications in the medication closet before leaving the area. Interview via phone on 8/25/21 with the facility's nurse confirmed medications should be locked prior to leaving the medication area.	W 382		