

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

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 08/25/2021
--	---	--	---

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 249 PROGRAM IMPLEMENTATION
CFR(s): 483.440(d)(1)

W 249

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

This deficiency will be corrected by the following actions:

10.23.2021

- A. All ISP's will be reviewed and revised as needed to ensure that all objectives are met.
- B. Client#5's ISP will be reviewed and revised to reflect the current need and proper techniques to be used to promote independence.
- C. Clinical supervisor will in-service all staff on the current ISP's and the use of all adaptive equipment.
- D. All individuals served will be afforded the opportunity to use all the adaptive equipment stipulated in the ISP.
- E. Site Supervisor will monitor and document on this weekly.
- F. Clinical Supervisor will monitor and document on this weekly.

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

[Signature] Program Manager 9/1/2021

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.

RECEIVED

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

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 08/25/2021
--	---	--	---

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 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
This deficiency will be corrected by the following actions:

- A. The Clinical Supervisor will receive written informed consent of the BSP's for all of the individuals in the home.
- B. The Clinical Supervisor will reach out to the guardian of client #5 to obtain temporary verbal consent until written consent is received
- C. The Clinical supervisor will document on this monthly until consent is received.

10.23.2021

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

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

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 08/25/2021
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 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 This deficiency will be corrected by the following actions: A. The Clinical Supervisor will ensure that all BSP's are reviewed and updated to meet the current needs of the individuals. B. The Clinical Supervisor will review the behavioral documentation along with the Site Supervisor, and Nurse, during core team meetings for and documentation to support any changes made. C. The Clinical Supervisor will conduct a team meeting for client #5 to review behavioral documentation and discuss any changes that need to be made to meet the client's current need. D. The Site Supervisor will monitor and document on the weekly. E. The Clinical Supervisor will monitor and document on this weekly. F. The Nurse will monitor and document on this monthly.	10.23.2021	
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			

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

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 08/25/2021
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 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	W 340 This deficiency will be corrected by the following actions: A. The nurse will be responsible for providing all staff with an in-service on appropriate medication administration methods. B. The nurse will ensure that the physician's orders for client #3 are updated and meet the current needs. C. Management will ensure that the proper medication administration methods are being used. D. The Site Supervisor will be responsible for monitoring and documenting on this weekly. E. The Clinical Supervisor will be responsible for monitoring and documenting on this weekly. F. The Nurse will be responsible for monitoring on this monthly.	10.23.2021	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESFORM 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 08/25/2021
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 340	<p>Continued From page 4</p> <p>clients (#3) observed receiving medications. The finding is:</p> <p>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.</p> <p>Interview on 8/25/21 with Staff C revealed they had been trained to use a kitchen spoon to dispense client #3's Metamucil.</p> <p>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".</p> <p>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".</p>	W 340		
W 362	<p>DRUG REGIMEN REVIEW CFR(s): 483.460(j)(1)</p> <p>A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly.</p> <p>This STANDARD is not met as evidenced by:</p>	W 362		

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

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 08/25/2021
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 362	<p>Continued From page 5</p> <p>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:</p> <p>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.</p> <p>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.</p>	W 362	<p>W 362 This deficiency will be corrected by the following actions:</p> <ul style="list-style-type: none"> A. The nurse will be responsible for contacting the pharmacy regarding information for all pharmacy reviews are completed and the information is easily found in each chart. B. The nurse will be responsible for reviewing this information to ensure there is no medical terminology that staff needs to be aware of or clarified. C. The nurse will ensure that the pharmacy reviews for client #2, #3, and #5 include the sufficient information regarding each client's drug regime. D. The nurse will monitor and document on the monthly. <p>10.23.2021</p>
W 368	<p>DRUG ADMINISTRATION CFR(s): 483.460(k)(1)</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>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:</p> <p>During observations of medication administration in the home on 8/25/21 at 6:55am, Staff C</p>	W 368	

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

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 08/25/2021
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 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 368 This deficiency will be corrected by the following actions: A. The nurse will be responsible for ensuring that all clients physician orders are updated. B. The nurse will be responsible for in-serving staff on the importance of administering each client's medication according to the physician's orders. C. The Site Supervisor will monitor and document on this weekly. D. The nurse will monitor and document on this monthly.	10.23.2021	
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	W 382 This deficiency will be corrected by the following actions: A. The nurse will in-service all staff on the proper storage techniques for all medication. B. The Site Supervisor will monitor staff C to ensure that the proper medication techniques are being using for medication storage techniques during medication administration. C. The Site Supervisor will monitor and document on this weekly. D. The nurse will monitor and document on this monthly.	10.23.2021	

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

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 08/25/2021
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 382	<p>Continued From page 7</p> <p>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.</p> <p>Interview on 8/25/21 with Staff C revealed they had been trained to lock medications in the medication closet before leaving the area.</p> <p>Interview via phone on 8/25/21 with the facility's nurse confirmed medications should be locked prior to leaving the medication area.</p>	W 382		