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 _____	C 02/01/2022

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	W 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider or the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	
W 154	An unannounced complaint survey was conducted on 2/1/22 for intake #NC00185282. A deficiency was cited during the investigation. STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to conduct a thorough investigation of an abuse allegation for 1 of 1 audit clients (#1). The finding is: Review on 2/1/22 of client #1's individual program plan (IPP) revealed client #1 had profound intellectual developmental disabilities, could answer yes or no questions and could make basic needs known. Client #1 was non-ambulatory and depended on staff for total care. Review on 2/1/22 of an Investigation Summary completed on 1/20/22 revealed on 1/17/22 at 9:25 PM staff A reported an allegation of abuse to staff C. The allegation was that a staff from first shift had hit, spanked and beat, client #1. The nurse performed a body check at the time and found no signs of trauma. The nurse concluded there were no marks or changes to client #1's skin, with no new findings on his body. Administrative staff were contacted and written statements were collected from some staff as well as an interview with client #1 and other unnamed staff. An additional review on 2/1/22 of a written statement by staff B written on 1/18/22 revealed	W 154	QP's and Supervisors will be in-serviced to investigate all allegations of neglect or abuse thoroughly to include interviewing other individuals that live on the same unit as the allegation. Program Manager and Administrator will ensure all allegations are investigated thoroughly and reported to appropriate officials. Will monitor all investigations monthly during our CQI meeting to ensure it is investigated thoroughly. DHSR - Mental Health FEB 18 2022 Lic. & Cert. Section	3.15.22

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

Sara Walker RN — Administrator — 2.11.22

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 154	Continued From page 1	W 154		

on 1/17/22 at the beginning of 1st shift, she found client #1, in an urine soaked bed, partially dressed, with vomit on clothing and not enough covers on his bed to keep him warm. A written statement by staff C on 1/17/22 revealed that she interviewed client #1 and when he was asked if he hurt anywhere, he placed his hand at throat. An additional written statement by staff D revealed when interviewing client #1 he would not discuss thee allegation of abuse, instead he requested a cold beer.

Review on 2/1/22 of the January 2022 direct support associates schedule for the Blue Bayou unit, revealed 3 staff working on 3rd shift, 1/16/22 who were not interviewed by the investigator.

Interviews on 2/1/22 were conducted with staff who included in the investigation. Staff A acknowledged that he worked with client #1 the nights of 1/16/22 and 1/17/22 but was not his assigned caregiver. Staff A revealed that he checked on client #1 on 1/17/22 at 9:25 pm and he appeared to be "shaken." Client #1 would not let staff A touch him or come near and indicated that he had been "hit and beat up." Staff A asked client #1 "was it somebody here now? and client #1 said no; then staff A asked did it happen on 1st shift and client #1 shook his head yes. Staff A immediately reported the allegation to his staff C who was in charge of the floor.

Interview on 2/1/22 with staff B revealed that when she started her rounds at the beginning of 1st shift on 1/17/22, she noticed that client #1 did not seem his normal friendly self. She described client #1 laying horizontally across his mattress in the fetal position, half dressed, not fully covered with blanket and soiled in a wet bed.

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W 154	Continued From page 2	W 154		

Interview on 2/1/22 with the investigator revealed that she was assigned to the abuse investigation on 1/18/22 and was told the incident happened on 1st shift on 1/17/22. The nurse had reported that client #1 did not have any injuries to suggest abuse and when staff D attempted to interview client #1 he only wanted to talk about beer. The investigator acknowledged that she did not consider interviewing staff from the previous day who had contact with client #1 or staff B about discovering that client #1 did not receive proper care before she came on duty. In addition, the investigator also acknowledged that she did not know if client #1's skin condition was being monitored and if a bruise may have appeared on another day. The investigator confirmed the facility had video surveillance in common areas and hallways but she failed to review any footage that might be related to this abuse investigation.

During an interview on 2/1/22 with the Administrator regarding the lack of resources explored for the abuse investigation of client #1 by the investigator; there was no explanation offered.