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 01/05/2023

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 survey was completed on January 5, 2023 for intakes #NC00196098 and #NC00196099. The complaints were substantiated. Deficiencies were cited.	W 000		
W 192	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were sufficiently trained on medication administration standard procedures. This affected 1 of 1 audit clients (#1). The finding is: Record review on 1/5/23 of client #1's medication administration record (MAR) for December, 2022 revealed a pattern of missed doses. 8:00AM Dose included these medications: Lacosamide, Lactulose, Oyster Shell Supplement, Senokot-S, Gabitril, Valproic Acid and Haldol IM. 12:00PM Dose included medications: Valproic Acid and Vitamin D3 9:00PM Dose included medications: Amantadine, Benztropine, Fluvoxamine, Lacosamide, Gabitril and Valproic Acid. Missed Doses: 12/4/22 at 8:00AM and 12:00PM; 12/14/22 at 9:00PM; 12/29/22 at 9:00PM; 12/30/22 at 9:00PM	W 192		

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

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W 192	Continued From page 1	W 192		

and 12/31/22 at 8:00AM and 12:00PM - there were no staff identified for the missed doses or a reason listed for the occurences.

12/13/22 at 8:00AM and 12:00PM; 12/17/22 at 8:00AM and 12:00PM; 12/18/22 at 12:00PM, Staff A did not explain the reasons for the missed doses.

12/17/22 at 9:00PM, Staff F did not explain the reason for the missed dose.

12/24/22 at 12:00PM, Staff G did not explain the reason for the missed dose.

12/24/22 at 9:00PM, Staff C did not explain the reason for the missed dose.

12/29/22 at 12:00PM, Staff D did not explain the reason for the missed dose.

Interview on 1/5/23 with Staff A acknowledged if client #1 refused her medications or there was a missed dose she was supposed the document the reason. Staff A stated she was supposed to notify her team leader whenever client #1 did not receive her medication. Staff A could not recall why the documentation was lacking on the MAR for December 2022.

Interview on 1/5/23 with the Director of Nursing (DON) revealed the unit nurse should review the MAR at the end of every shift to make sure everything looked good with the medications. At the end of every month, the team leader also reviews the MAR for discrepancies. The DON stated the physician assistant should be notified if there are mediation errors. The DON also stated it should have been determined if the medication

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W 192	Continued From page 2 in the bubble packs were punched out and given, but not recorded or if the medication was never administered. The DON did not have a report on the medication discrepancies for client #1 in December, 2022.	W 192		
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 record review and staff interviews, the facility failed to ensure medications were administered, as prescribed for 1 of 1 audit clients (#1). The finding is: Record review on 1/5/23 of client #1's medication administration record (MAR) for December, 2022 revealed a pattern of medication refusals or missed doses. Refused Medications: 8:00AM medications included: Lacosamide, Lactulose, Oyster Shell Supplement, Senokot-S, Gabitril, Valproic Acid and Haldol IM. 12/1/22 at 8:00AM, Staff D recorded client #1 refused medications. 12/28/22 at 8:00AM, the Assistant Director of Nursing (ADON) recorded client #1 refused medications. 12:00PM medications included: Valproic Acid and Vitamin D3 12/5/22 at 12:00PM, Staff recorded client #1	W 368		

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W 368	Continued From page 3	W 368		

refused medications.
12/6/22 at 12:00PM, Staff D recorded client #1 refused medications.
12/16/22 at 12:00PM, Staff B recorded client #1 refused medications.
12/28/22 at 12:00PM, Staff H recorded client #1 refused medications.

9:00PM medications included: Amantadine, Benztropine, Fluvoxamine, Lacosamide, Gabitril and Valproic Acid.

12/1/22; 12/2/22; 12/6/22; 12/16/22; 12/21/22 and 12/28/22 at 9:00PM, Staff B recorded client #1 refused medications.

12/5/22 at 9:00PM, Staff E recorded client #1 refused medications.

Missed Doses:

12/4/22 at 8:00AM and 12:00PM; 12/14/22 at 9:00PM; 12/29/22 at 9:00PM; 12/30/22 at 9:00PM and 12/31/22 at 8:00AM and 12:00PM - there were no staff identified for the missed doses or a reason listed for the occurrences.

12/13/22 at 8:00AM and 12:00PM; 12/17/22 at 8:00AM and 12:00PM; 12/18/22 at 12:00PM, Staff A did not explain the reasons for the missed doses.

12/17/22 at 9:00PM, Staff F did not explain the reason for the missed dose.

12/24/22 at 12:00PM, Staff G did not explain the reason for the missed dose.

12/24/22 at 9:00PM, Staff C did not explain the

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W 368	Continued From page 4 reason for the missed dose. 12/29/22 at 12:00PM, Staff D did not explain the reason for the missed dose. Review on 1/5/23 of the client #1's Individual Program Plan (IPP) dated 10/26/22 revealed, in order to address her targeted behaviors of elopement, skin picking, aggression and psychotic talk, medication compliance remained a high priority given her seizure disorder and psychiatric needs. Review on 1/5/23 of the Psychology follow up form revealed there were medical concerns with client #1 who had recent breakthrough seizures and behavioral concerns. Interview on 1/5/23 with Staff A revealed she was aware client #1 had behaviors and a history of refusing her medications. Staff A stated that sometimes, client #1 may go days without taking her medication which resulted in Staff A notifying her team leader. Interview on 1/5/23 with the Registered Nurse (RN) supervisor revealed client #1 had a history of refusing medication, but would receive medications successfully, with several attempts by the nurse. Interview on 1/5/23 with the Director of Nursing (DON) revealed the nurse on unit should check at the end of the shift to make sure everything is good. If there are missed medications, the physician assistant should be notified that medications were not given. The DON stated, this would be considered a medication error.	W 368		