

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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			
W 141	<p>A complaint survey was completed on 4/21/23 for intakes #NC00200185, #NC00200251 and #NC00200176. The complaints were substantiated. Deficiencies were cited.</p> <p>CLIENT FINANCES CFR(s): 483.420(b)(1)(ii)</p> <p>The facility must establish and maintain a system that precludes any commingling of client funds with facility funds or with the funds of any person other than another client. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to prevent commingling of personal funds with clients accounts. This affected 2 of 14 audit clients (#7 and #9). The finding is:</p> <p>Review on 4/20/23 of the Resident Statement Landscape (RSL) dated on 2/22/23 for client #9 revealed on 6/14/22 two withdrawals were made for personal expenses which totaled \$1,125.77. Three invoices for online store purchases had the name of client #7 handwritten on it. The purchases were for \$881.83 on 5/2/22, \$93.94 and \$144.10 on 5/10/22. An additional review on 4/20/23 of the quarterly RSL for client #9 ranging from 1/4/23 to 4/3/23 revealed there was no deposit for \$1,125.77 returned to his account.</p> <p>Interview on 4/20/23 with the guardian of client #9 revealed last year the facility accidentally took money from client #9's account and paid expenses for client #7. The guardian revealed when she found out about it in June 2022, she requested a refund through the qualified intellectual disabilities professional (QIDP). The guardian revealed client #9 had not received the</p>	W 141			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 141	Continued From page 1 requested refund yet. Interview on 4/20/23 with the QIDP revealed she discovered the facility accidentally paid for client #7's purchases with client #9's funds in May 2022. The QIDP revealed on the behalf of the guardian, she requested a refund from the business office manager (BOM) but the facility had not yet approved refunding the account. Interview on 4/20/23 with the BOM revealed she received receipts last year from the QIDP to reimburse money spent for online purchases for client #9. The BOM revealed she mistook the name on the invoice for client #9 and accidentally paid for client #7's items but was not aware of her actions until the QIDP spoke to her on 2/22/23 when she reviewed the RSL and noticed the extra withdrawal. The BOM had emails, starting with 4/2/23 when she requested a refund for client #9 with the accounts receivable department but was told they did not handle refunds for petty cash. The BOM revealed she was still trying to get the refund approved. Interview on 4/21/23 with the Director of Operations Eastern Region (DOER) revealed that he was unaware of the resident funds account issue until today. The DOER revealed he would look into it and would authorize for the money to be transferred from client #7's account to reimburse client #9 for the accidental withdrawal.	W 141			
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met.	W 318			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 318	Continued From page 2	W 318			
W 331	<p>This CONDITION is not met as evidenced by: The facility failed to: provide nursing oversight regarding the administration of medications (W331), failed to ensure pharmacy services had medications refilled as needed (W361), ensure all medications were administered in compliance with physician orders (W368) and ensure complete and accurate recording was available (W375). The cumulative effects of these systemic practices resulted in the facility's failure to provide statutorily mandated services in health care.</p> <p>NURSING SERVICES CFR(s): 483.460(c)</p> <p>The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to: provide nursing services in accordance with the needs of 11 of 14 audit clients (#1, #2, #3, #4, #6, #8, #10, #11, #12, #13 and #14. The findings are:</p> <p>A. Review of medication error reports between 2/12/23-4/17/23 revealed 15 medication errors which included:</p> <ol style="list-style-type: none"> 1. Client #4: (2/12/23) Staff gave morning morning medication instead of evening medications. Gave Lacosamide Tablet 100mg. "Staff not paying close attention." 2. Client #4: (2/14/23) Tramadol HCL 50 mg. (1/2 tablet 25 mg.) 2 doses not accounted for. 3. Client #10 : (2/21/23) Valium 2mg. was omitted at 8am. Staff E omitted medication; detected at 	W 331			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 331	Continued From page 3 5pm. 4. Client #3: (2/21/23) Clonazepam 0.5mg. dose omitted at 12pm. 5. Client #11: (3/9/23) Staff D failed to administer Naltrexone 50 mg. (1) tablet at 8pm. Medication not given, MAR was signed. 6. Client #14: (3/10/23) Staff D failed to administer Metformin 750 mg. ER(1) tablet at 5pm. MAR was signed. 7. Client #14: (3/10/23) Staff D failed to administer Prednisone 20 mg. tablets at 5pm on 3/10/23 and MAR was not signed. 8. Client #11: (3/11/23) Staff D did not administer Naltrexone 50 mg. (1) tablet at 8am medication pass. Pill not punched out but medication administration record (MAR) was signed. 9. Client #1: (3/16/23): Staff C discovered extra pill in 15 day bubble at 1pm (medication not identified). 10. Client #1: (3/16/23) Staff C failed to give day 15 in bubblepack (medication not identified). 11. Client #2: (3/18/23 and 3/19/23) Staff C failed to administer Amoxi-Chlor suspension at 8am. MAR was not signed. Should have received 10mg. Amoxi-Chlor suspension at 8am. MAR not completed; should have received 10 ml. at 8am equaling 20 ml. however there still 40 ml. in the bottle/ New bottle should have been started . Administrator notified. Medication not given. Physician notified. 12. Client #6: (3/30/23) Staff C discovered Clonazepam 1 mg. remained in bubble for 3/29/23. Noticed during am medication pass. Physician notified. 13. Client #13: (4/7/23) Phenobarbital card had an extra dose and was not given at 6am on 4/7/23. 14. Client #12: (4/11/23) Staff B administered Valium 5mg. twice at 7pm and at 8pm. Physician	W 331			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 331	<p>Continued From page 4</p> <p>notified.</p> <p>15. Client #8: (4/11/23) Staff B administered Klonopin 0.5 mg. twice at noon. Physician notified.</p> <p>Interview on 4/20/23 with a Nurse supervisor revealed the Director of Nursing (DON) had been out on medical leave for over 2 months and that the Nurse Team Leads were responsible for following up on medication errors and scheduling retraining of staff when training issues were identified. Further interview confirmed there had been no additional medication administration training since 1/13/23.</p> <p>Interview on 4/20/23 with the DON confirmed she had been out on medical leave and was not made aware of the multiple medication errors between 2/12/23-4/11/23. She stated an Assistant Director of Nursing (ADON) had been hired however, that Nurse left his position in March 2023. Further interview confirmed Nursing staff were responsible for detecting medication errors and training issues when they were identified.</p> <p>Interview on 4/21/23 with the Corporate Director of Nursing revealed she was not aware of the multiple medication errors between 2/12/23-4/11/23. Further interview confirmed the facility had a quality assurance review of medication errors, of the medication carts and MARS however, she admitted these multiple medication errors confirmed the need for medication retraining.</p> <p>B. Review on 4/20/23 of a disciplinary action dated 3/21/23 revealed staff A who was identified as the medication technician walked out of the facility on 3/9/23 with client #12's narcotic</p>	W 331			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 331	<p>Continued From page 5</p> <p>medication in her lab coat resulting in client #12 not having this medication available after a substantial surgical procedure.</p> <p>Review on 4/20/23 of client #12's record revealed a Physician consult dated 5/12/22 which confirmed client #12 was diagnosed with Triple Negative Breast Cancer on the left side at the local surgical clinic. Further review confirmed she underwent a bilateral mastectomy on 2/20/23. Review on 4/20/23 of physician notes dated 3/8/23 revealed the physician prescribed Narco 5/325 mg. by mouth every 6 hours for pain. There were 20 pills prescribed in the bottle.</p> <p>Review on 4/20/23 of the medication error reports revealed there was no medication error report for this medication omission nor were there statements from staff regarding this incident.</p> <p>Review on 4/20/23 of the facility's medication error policy dated October 2018 revealed all drugs, devices and related materials will be administered by, or under the supervision of nursing or other personnel in accordance with federal and state laws. Medications will be administered in compliance with physician orders. If medications are administered outside of the time window, the time of administration must be documented and nursing must be notified. Medication given outside of the time frame will constitute a medicine variance or medication error. The (company name) medication error report should be completed.</p> <p>Interview on 4/20/23 with direct care staff A revealed she worked overnight on 3/8/23 and was the medication technician assigned to client #12. Staff A stated she had signed off on the narcotic</p>	W 331			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 331	<p>Continued From page 6</p> <p>medication sheet around 8am and was walking over to the yellow unit to take this medication to Nurse D. Staff A stated she received a personal phone call around 8am, put the bottle of narcotic pain medication in her pocket and mistakenly clocked out of work and took the medication home and drove to another area of the state</p> <p>Interview on 4/20/23 with Nurse D revealed she was working on 3/9/23 and qualified intellectual disabilities professional (QIDP) told her client #12 was experiencing discomfort around the surgical area on her chest. Nurse D stated she walked to the medication cart and realized client #12's Narco 5/325 mg. was not in the locked medication cart. Nurse D stated she immediately began talking to staff and looking for client #12's medication. Nurse D then confirmed that a Nurse Supervisor heard her talking about this medication and she assumed responsibility of tracking this medication down for client #12. Nurse D stated the decision was made to go ahead and give client #12 Ibuprofen 800mg. that was also prescribed for discomfort.</p> <p>Interview on 4/20/23 with the Nurse Supervisor revealed on 3/9/23 when she discovered client #12's Narco 5/325 mg was missing, she went to the narcotic sheet and medication technician schedule to see who the last person was scheduled to give medications on the morning of 3/9/23. The Nurse Supervisor stated after several phone calls on 3/9/23 they were able to locate staff A and instruct her to come directly back to the facility. The Nurse Supervisor stated staff A arrived back to the facility around 6pm with client #12's Narco 5/325 mg. pill bottle and that she individually counted each pill to make certain all pills were accounted for.</p>	W 331			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 331	<p>Continued From page 7</p> <p>Interview on 4/20/23 with the DON revealed she was unaware of this medication error dated 3/9/23 by staff A taking client #12's narcotic medication out of the facility. Further interview revealed this incident should have been written up as a medication error report with staff statements and needed medication re-training.</p> <p>Interview on 4/20/23 with the administrator revealed there was no medication error report for this incident dated 3/9/23 because they knew what happened to the medication and did not feel this was a medication error. Further interview revealed the facility talked with staff A and issued a written disciplinary action dated 3/21/23. Additional interview revealed there had been no additional medication administration training since the last inservice dated 1/13/23.</p> <p>C. Nursing failed to follow-up on several medication administration discrepancies as required.</p> <p>Review on 4/20/23 of client #12's medication administration record (MAR) for March 2023 revealed the following:</p> <p>1. Narco 5/325mg. Give (1) tablet by mouth every 6 hours for pain. (prescribed at 6pm, 12 am, 6am, 12 pm) dated 3/9/23. The following dates/times are not recorded: 3/9/23 at 12pm 3/12/23 at 12am 3/12/23 at 6am 3/13/23 at 12am 3/13/23 at 6am 3/14/23 at 12am 3/14/23 at 6am</p>	W 331			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 331	Continued From page 8 3/15/23: at 6pm, 12am, 6am and 12pm 2. Clindamycin 150mg. by mouth 3 times per day for 10 days #30. The following dates/times are not recorded: 3/10/23 at 6pm 3/17/23 at 6pm 3. Nystatin powder apply four times per day to affected area. The following dates/times are not recorded: 3/10/23 at 8pm 3/11/23-3/20/23 at 8pm 3/11/23-3/20/23 at 12am Interview on 4/20/23 with the Nurse Supervisor and administrator confirmed there were no medication error reports for these medication documentation errors for client #12. Further interview on 4/20/23 with the administrator revealed it was the responsibility of the Nursing Team leads to follow up on these medication discrepancies in the absence of the DON.	W 331			
W 361	PHARMACY SERVICES CFR(s): 483.460(i) The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the	W 361			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 361	<p>Continued From page 9</p> <p>facility failed to ensure pharmacy services for 1 of 14 audit clients (#5) provided prescribed medication. The finding is:</p> <p>Review on 4/20/23 of the medication administration review (MAR) for March 2023 for client #5 revealed on 3/28/23 she received Haloperidol 1mg IM at 9:00am. On 3/29/23 and 3/30/23 the medication was out of stock and was not documented as not given due to pharmacy.</p> <p>Review on 4/21/23 of the Physicians Order dated 3/29/23 revealed instructions to hold Haldol scheduled dose today. Staff may use Ativan 1mg for crisis medication until Haldol comes in from the pharmacy on 3/30/23.</p> <p>Interview on 4/20/23 with Nurse E revealed that only nurses give the injections. Nurse E stated that when the medications are out, they call the pharmacy to get the medication restocked. The nurse then calls the doctor to get an order to hold the medication until it can be delivered from the pharmacy. Currently when medications are ordered, Nurse E stated it arrives the next day. Nurse E also stated that they can request back up pharmacy services when speaking with the pharmacy.</p> <p>Interview on 4/20/23 with Nurse A revealed that when the medication ran out, they should call the doctor and notify the pharmacy that a refill is needed; if the medication is needed immediately, they can request back up pharmacy services to deliver within a day. Nurse A revealed that the pharmacy was unable to refill Haloperidol 1mg IM because of the dose. The pharmacy called 5 separate back up pharmacies but the only dose of Haloperidol that was in stock was 10 x stronger</p>	W 361			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 361	<p>Continued From page 10</p> <p>then what was needed. Nurse A revealed that she was aware that agency staff were using the crisis dose of Haloperidol 1mg IM for the scheduled dose since it was available, instead of someone reordering the medication.</p> <p>Interview on 4/21/23 with the corporate nurse revealed client #5 had her order for Haloperidol 1mg IM revised in December 2022 from PRN to a daily scheduled dose. The corporate nurse revealed that client #5 still had a separate prescription for Haloperidol 1mg IM prn. The corporate nurse revealed the facility was in the process of migrating pharmacy services from the former vendor to a new vendor, which started last month. In preparation for the change, the facility attempted to collect all physician's orders to ensure the new pharmacy received them. The corporate nurse believed that the new December 2022 order for Haloperidol 1mg IM daily was not put into the system for the new pharmacy and it ran out after staff completed the daily and prn doses. The corporate nurse acknowledged the medication should not have ran out and should have been refilled when the last dose was given on 3/28/23.</p> <p>Interview on 4/21/23 with the Physician's Assistant (PA) revealed he was contacted on 3/29/23 by the nurse and asked to authorize the use of Ativan 1mg because the Haloperidol 1mg IM had ran out and would take a day to arrive from pharmacy. The PA revealed he authorized holding Haloperidol 1mg IM and replaced it with Ativan 1mg IM expecting the medication to arrive on 3/30/23. The PA revealed he learned the medication did not arrive for the 9:00am dose on 3/30/23 and was delivered during evening hours.</p>	W 361			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 368 W 368	<p>Continued From page 11</p> <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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure medications were administered in accordance with physician's orders. This affected 1 of 14 audit clients (#12). The finding is:</p> <p>Review on 4/20/23 of client #12's medication administration record (MAR) for March 2023 revealed the following:</p> <p>A. Narco 5/325mg. Give (1) tablet by mouth every 6 hours for pain. (prescribed at 6pm, 12 am, 6am, 12 pm) dated 3/9/23. The following dates/times are not recorded: 3/9/23 at 12pm 3/12/23 at 12am 3/12/23 at 6am 3/13/23 at 12am 3/13/23 at 6am 3/14/23 at 12am 3/14/23 at 6am 3/15/23: at 6pm, 12am, 6am and 12pm</p> <p>B. Clindamycin 150mg. by mouth 3 times per day for 10 days #30. The following dates/times are not recorded: 3/10/23 at 6pm 3/17/23 at 6pm</p> <p>C. Nystatin powder apply four times per day to affected area. The following dates/times are not recorded: 3/10/23 at 8pm</p>	W 368 W 368			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 368	Continued From page 12 3/11/23-3/20/23 at 8pm 3/11/23-3/20/23 at 12am Interview on 4/20/23 with the Nurse Supervisor and administrator confirmed there were no medication error reports for these medication documentation errors for client #12. Further interview revealed it was not confirmed whether these were documentation errors or whether client #12 received these medications as ordered by the physician. Further interview on 4/20/23 with the administrator revealed it was the responsibility of the Nursing Team leads to follow up on these medication discrepancies in the absence of the DON.	W 368			
W 375	DRUG ADMINISTRATION CFR(s): 483.460(k)(8) The system for drug administration must assure that drug administration errors and adverse drug reactions are recorded. This STANDARD is not met as evidenced by: Based on record review and interview, the system for medication administration failed to ensure complete and accurate recording was available for 33 medication errors for client #12 in the month of March 2023. The findings are: A. Review on 4/20/23 of a disciplinary action dated 3/21/23 revealed staff A who was medication technician walked out of the facility on 3/9/23 with client #12's narcotic medication in her lab coat resulting in client #12 not having this medication available after a substantial surgical procedure.	W 375			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 375	<p>Continued From page 13</p> <p>Review on 4/20/23 of client #12's record revealed a Physician consult dated 5/12/22 which confirmed client #12 was diagnosed with Triple Negative Breast Cancer on the left side at the local surgical clinic. Further review confirmed she underwent a bilateral mastectomy on 2/20/23. Review on 4/20/23 of physician notes dated 3/8/23 revealed the physician prescribed Narco 5/325 mg. by mouth every 6 hours for pain. There were 20 pills prescribed in the bottle.</p> <p>Review on 4/20/23 of the medication error reports revealed there was no medication error report for this medication omission nor were there statements from staff regarding this incident.</p> <p>Review on 4/20/23 of the facility's medication error policy dated October 2018 revealed all drugs, devices and related materials will be administered by, or under the supervision of nursing or other personnel in accordance with federal and state laws. Medications will be administered in compliance with physician orders. If medications are administered outside of the time window, the time of administration must be documented and nursing must be notified. Medication given outside of the time frame will constitute a medicine variance or medication error. The (company name) medication error report should be completed.</p> <p>Interview on 4/20/23 with direct care staff A revealed she worked overnight on 3/8/23 and was the medication technician assigned to client #12. Staff A stated she had signed off on the narcotic medication sheet around 8am and was walking over to the yellow unit to take this medication to Nurse D. Staff A stated she received a personal phone call around 8am, put the bottle of narcotic</p>	W 375			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 375	<p>Continued From page 14</p> <p>pain medication in her pocket and mistakenly clocked out of work and took the medication home and drove to another area of the state</p> <p>Interview on 4/20/23 with Nurse D revealed she was working on 3/9/23 and the qualified intellectual disabilities professional (QIDP) told her client #12 was experiencing discomfort around the surgical area on her chest. Nurse D stated she walked to the medication cart and realized client #12's Narco 5/325 mg. was not in the locked medication cart. Nurse D stated she immediately began talking to staff and looking for client #12's medication. Nurse D then confirmed that a Nurse Supervisor heard her talking about this medication and she assumed responsibility of tracking this medication down for client #12. Nurse D stated the decision was made to go ahead and and give client #12 Ibuprofen 800mg. that was also prescribed for discomfort.</p> <p>Interview on 4/20/23 with the Nurse Supervisor revealed on 3/9/23 when she discovered client #12's Narco 5/325 mg was missing, she went to the narcotic sheet and medication technician schedule to see who the last person scheduled to give medications was on the morning of 3/9/23. The Nurse Supervisor stated after several phone calls on 3/9/23 they were able to locate staff A and instruct her to come directly back to the facility. The Nurse Supervisor stated staff A arrived back to the facility around 6pm with client #12's Narco 5/325 mg. pill bottle and that she individually counted each pill to make certain all pills were accounted for.</p> <p>Interview on 4/20/23 with the DON revealed she was unaware of this medication error dated 3/9/23 by staff A taking client #12's narcotic</p>	W 375			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 375	<p>Continued From page 15</p> <p>medication out of the facility. Further interview revealed this incident should have been written up as a medication error report with staff statements and needed medication re-training.</p> <p>B. Review on 4/20/23 of client #12's medication administration record (MAR) for March 2023 revealed the following 32 medication discrepancies:</p> <p>1. Narco 5/325mg. Give (1) tablet by mouth every 6 hours for pain. (prescribed at 6pm, 12 am, 6am, 12 pm) dated 3/9/23. The following dates/times are not recorded: 3/9/23 at 12pm 3/12/23 at 12am 3/12/23 at 6am 3/13/23 at 12am 3/13/23 at 6am 3/14/23 at 12am 3/14/23 at 6am 3/15/23: at 6pm, 12am, 6am and 12pm</p> <p>2. Clindamycin 150mg. by mouth 3 times per day for 10 days #30. The following dates/times are not recorded: 3/10/23 at 6pm 3/17/23 at 6pm</p> <p>3. Nystatin powder apply four times per day to affected area. The following dates/times are not recorded: 3/10/23 at 8pm 3/11/23-3/20/23 at 8pm 3/11/23-3/20/23 at 12am</p> <p>Interview on 4/20/23 with the Nurse Supervisor and administrator confirmed there were no medication error reports for these medication</p>	W 375			

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

PRINTED: 04/27/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G006	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/21/2023
NAME OF PROVIDER OR SUPPLIER BEAR CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 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 375	Continued From page 16 documentation errors for client #12. Further interview on 4/20/23 with the administrator revealed it was the responsibility of the Nursing Team leads to document medication errors and to follow up on these medication discrepancies in the absence of the DON.	W 375			