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 ______	11/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BASS LAKE	**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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 3 audit clients (#5) had the opportunity to choose their personal preference regarding the freedom of movement in the home. The finding is: During observations at the home on 11/6/23 at 4:52 pm, Staff A was on the backyard patio with client #5. Staff A was observed to sit in a chair with his back to the door and held a garden bow rake across his knees. Client #5, stood in front of Staff A and was moving toward the door, but Staff A did not get up from the chair. Client #5, made another attempt to walk toward the door and Staff A was observed to remove the rake from his knee and held it straight up in his right hand, tapping it on the ground. Staff A remained in his seat. The Surveyor observed the home manager (HM) coming down the hall at 4:55 pm and asked her to look out the door's window. The HM opened the door and immediately told Staff A to get up, that he could not block the door. Client #5 started to walk toward the door, when Staff A was observed to pivot in front of client #5 and touched the client's shoulders. The HM was observed to tell Staff A that client #1 was allowed to come into the house. Client #1 entered the home and was assisted in getting ready for dinner.	W 125		

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.

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W 125	Continued From page 1 Record review on 11/6/23 of the Behavior Support Plan, dated 12/15/22 for client #5 revealed he might have behaviors when he is redirected away from a preferred activity. In addition, the 6/18/23 Individual Program Plan (IPP) revealed he did not like to engage in activities for more then 5 minutes. Interview on 11/6/23 with Staff A revealed that he acknowledged holding the bow rake for no reason and had sat in front of the door to avoid sun glare. Staff A denied preventing client #5 from entering the house. Interview on 11/6/23 with the HM revealed client #5 was allowed to go in and out of the house at any time. Interview on 11/6/23 with the new Qualified Intellectual Disabilities Professional (QIDP) for the home acknowledged that he overheard the patio incident but offered no explanation.	W 125		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to provide each employee with initial and continuing training that enable the employee to perform duties effectively, efficiently, and competently in the area of cooking safely for the clients' meals. The finding is: During observations in the home on 11/6/23 at	W 189		

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W 189	Continued From page 2 4:20 pm, Staff C had a large pot filled with frozen carrots and water on a ceramic stovetop. The water had not begun to boil; with the burner turned on high. After a few minutes, Staff C reduced the heat to low-medium. During the meal preparation, Staff C walked out of the kitchen for several minutes and went onto the clients' bedroom hallway. In addition, Staff C was operating an air fryer on the kitchen counter. Next to the hot appliance, was a plastic bag containing the frozen chicken tenders. Staff C and the home manager (HM) were observed commenting how the air fryer got too hot and would burn up food if not monitored closely. The kitchen had a "burnt oven" smell, while the food was cooking. Review of fire drills conducted in the home, revealed the following incidents: 1. On 12/4/22 at 4:00 pm, Staff B and the HM recorded an unplanned event due to the pan got hot while cooking and started smoking. Staff B and the HM had to evacuate the 6 clients in the home and wait for the fire department to respond. 2. On 4/4/23 at 1:15 pm, Staff B and the HM recorded an unplanned event due to the pan got too while staff prepared lunch for the clients. The smoke detector was activated and the fire department responded. 3. On 4/30/23 at 7:00 pm, Staff A and the HM recorded, while cooking, the smoke detector went off. Interview on 11/7/23 with the HM revealed the home received a new stove with a ceramic stovetop that staff were not accustomed to cooking on. The HM was aware of the smoke	W 189		

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W 189	Continued From page 3 detector, located inside the kitchen, going off due to the pans getting too hot. The HM acknowledged that she advised staff to open the window in the kitchen and crack the door open in the dining room when cooking, to combat the sensitivity of the smoke detector. The HM further stated that she had observed staff turn the oven and stovetop to the highest heat when starting out cooking. Interview on 11/7/23 with the Program Director (PD) revealed she joined the company in June, 2023 and only recently spent time at the home. The PD acknowledged reviewing the monthly fire reports but did not take note of the cooking incidents.	W 189		
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 reviews and interview, the facility failed to ensure written informed consents were obtained for restrictive Behavior Support Plans (BSP) for 2 of 3 sampled clients (#1 and #5). The findings are: A. Review on 11/7/23 of client #1's Behavior Support Guidelines on 12/15/22 allowed her to have Lorazepam before medical/dental procedures. The guardian signed the consent on 12/15/22, but it expired 6 months after the date, since using a restrictive intervention. Review of the medication administration record (MAR) for August, 2023 recorded client #1 received on	W 263		

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W 263	Continued From page 4	W 263		

8/16/23, Lorazepam 2mg, 30 minutes prior to doctor's appointment on 9/18/23.

B. Review on 11/7/23 of client #5's BSP on 12/15/22 revealed he was prescribed the following behavioral medications: Risperidone, Sertraline, Benztropine, Buspirone, Divalproex, Guanfacine, and Hydroxyzine. Client #5 was also on a desensitization plan for doctor appointments. On 1/18/23, his guardian signed the consent for the plan, but it had expired on 7/18/23.

Interview on 11/7/23 with the nurse confirmed client #1 received a dose of Lorazepam, per her desensitization program, when having dental treatment in August. The nurse revealed client #5 took medications due to a behavior plan. The nurse acknowledged that both consents should have been renewed again six months after signed by the guardians.