Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		MHL0601296	B. WING		02/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE	
BASS LAI	NE GROUP HOME	622 BASS	LANE		
		CHARLOT	TE, NC 28270		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
V 000	INITIAL COMMENTS	:	V 000		
	An annual survey wa Deficiencies were cite	s completed on 2/22/24. ed.			
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.			
	_	d for 2 and currently has a vey sample consisted of ents.			
V 118	27G .0209 (C) Medic	ation Requirements	V 118		
	V 118 27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administering the				

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		MHL0601296	B. WING		02/	22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		622 BASS	LANE			
BASS LAI	NE GROUP HOME	CHARLO	TTE, NC 28270			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLÉTE DATE
V 118	Continued From page	e 1	V 118			
	(5) Client requests for checks shall be recor	r medication changes or ded and kept with the MAR pointment or consultation				
	facility failed to ensur- administered to client person authorized to	ews and interviews, the e medications were s on the written order of a prescribe drugs and failed to re kept current for 1 of 2				
	Review on 2/19/24 of -Admission date of 12 -Diagnoses of Modera Developmental Disab Epilepsy.	ate Intellectual				
	orders revealed: -3/8/22 PreviDent 500 treatment)1.1% topica amount of paste on to for 2 minutes. After be rinse, eat or drink for at bedtime12/8/23 Tretinoin (sk Apply small amount to -12/29/22 Eucerin Cre (ounce) Apply to left a daily for seven days.	al paste: Place a pea size both brush and brush teeth rushing spit out. Do not 30 minutes. Use once a day in treatment) 0.025% Cream				

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Division of	of Health Service Regul	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	TED
		MHL0601296	B. WING		02/22	/2024
	201/1252 02 01/1251 155	0.70557.4				
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE		
BASS LAN	NE GROUP HOME	622 BAS	_			
		CHARLO	OTTE, NC 28270			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	I	COMPLETE DATE
TAG	REGOLATOR ORE	SO BENTI TING IN GRAMATION)	TAG	DEFICIENCY)	WAIL	
V 440	O (1 1 E		1/440			
V 118	Continued From page	2	V 118			
	-No discontinuation or	rder for Tretinoin, Eucerin,				
	or Clinda-Benzoyl Per	roxide.				
	Review on 2/19/24 of					
		igh February 19, 2024				
	revealed:					
	-PreviDent was docur	nented as applied				
	1/1/24-2/18/24.	as "D/C" (discontinued) with				
		as "D/C" (discontinued) with				
	the December and Ja	the days of the month on				
		ented as administered				
	2/1/24-2/3/24 and 2/5					
		documented as "D/C" with a				
		ne days of the month on the				
	December MAR.	io days of the mentil off the				
		documented as applied the				
		ary and 2/1/24-2/19/24 at				
	7am and 2/1/24-2/18/	•				
	-Clinda-Benzoyl Pero:	xide was documented as				
	"D/C" with a line striki	ng through the days of the				
	month on the Decemb	per and January MAR, with				
	a note on the back of	the December MAR				
		nda Benzoyl Per 1-5% pump				
		idmistrate to [client #1]! Not				
	available from pharma					
	,	xide was documented as				
	applied 2/2/24-2/19/24	4.				
	Observation on 2/10/	24 at 1:25pm of client #1's				
	medication bin reveal					
		eu. enzoyl Peroxide, Tretinoin,				
	and Eucerin Cream w					
	and Edocilli Orealli W	ore not in the facility.				
	Attempted interview of	on 2/20/24 with client #1 was				

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interviewed.

unsuccessful because he declined to be

Interview on 2/22/24 with staff #1 revealed: -Client #1's [over the counter] toothpaste was in

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DIVISION	n Health Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
				_		
			B. WING			
		MHL0601296	B. W		02/2	2/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		622 BAS	SLANE			
BASS LANE GROUP HOME			TTE, NC 28270			
(V4) ID	SLIMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE	DATE
				DEFICIENCY)		
V 118	Continued From page	<u>.</u> 3	V 118			
	. •					
		that (over the counter				
	toothpaste) when I br					
	-"I don't know" who w	rote "D/C" on client #1's				
	December and Janua	ry MAR for Clinda-Benzoyl				
	Peroxide and Tretinoi	n and client #1's December				
	MAR for the Eucerin (Cream.				
	-"I gave that (Clinda-E	Benzoyl Peroxide)" in				
	February."					
	•	etinoin). I think that it might				
	have been D/C'd on the					
	-"[Client #1] should ha	ave had that Eucerin Cream.				
		oom. They forget to put it				
		et). If I see it, I put it in the				
	,	ise he had a skin irritation,				
		s on his skin and irritates his				
	chest."	is of the ordinaria intrace the				
		as using it (Eucerin Cream)				
	= = = = = = = = = = = = = = = = = = = =	red up. I think something				
		e backIt does say 7 days				
	on the MAR. You are					
	-"I need to take a refr					
	(medication) class. I					
	medication is D/C'd it	has to have a D/C order."				
	Interview on 2/20/23 v	with the Qualified				
		= -				
	Professional (QP) rev					
		r the counter toothpaste				
	rather than PreviDent					
	-"I don't think the crea					
		ind Eucerin) were D/C'd. I				
		ritten (on the MAR). It may				
	•	rescription that was not				
	•	as never a D/C order. I				
		rder. I dropped the ball on				
	that one."					
	D (" (" ;					
	Due to the failure to a					
	medication administra	ation, it could not be				
	DETERMINED IT CHAPT #7	I TOCOIVOR DIS MORICATIONS	1	1	1	

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as ordered by the physician.

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		MHL0601296	B. WING		02/	22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE ZIP CODE	·	
	10115211 011 001 1 21211	622 BAS		, 3332		
BASS LA	NE GROUP HOME		TTE, NC 28270			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLETE DATE
V 119	27G .0209 (D) Medica	ation Requirements	V 119			
	10A NCAC 27G .0209	MEDICATION				
	REQUIREMENTS	9 WEDICATION				
	(d) Medication dispos	al:				
	(1) All prescription an					
	medication shall be d	isposed of in a manner that				
		ion or accidental ingestion.				
		bstances shall be disposed				
		shing into septic or sewer r to a local pharmacy for				
		of the medication disposal				
	shall be maintained b					
		specify the client's name,				
		ength, quantity, disposal				
		signature of the person				
	disposing of medication witnessing destruction					
		nces shall be disposed of in				
		North Carolina Controlled				
		90, Article 5, including any				
	subsequent amendm	ents. f a patient or resident, the				
		er drug supply shall be				
		unless it is reasonably				
		ient or resident shall return				
	_	uch case, the remaining				
		be held for more than 30				
	calendar days after th	ne date of discharge.				
	This Rule is not met					
		ews, observations, and				
	interviews, the facility	rescription medication was				
		ner that guards against				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		MHL0601296	B. WING		02/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		622 BASS	LANE		
BASS LAI	NE GROUP HOME		TTE, NC 28270		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
V 119	Continued From page	e 5	V 119		
	accidental ingestion a (#1). The findings are	affecting 1 out of 2 clients e:			
	Review on 2/19/24 of -Admission date of 12	f client #1's record revealed: 2/1/14.			
	-Diagnoses of Moder	ate Intellectual			
	Developmental Disab	oility, Cerebral Palsy,			
	Epilepsy.	ad 12/29/22 Catanhil Daily			
		ed 12/28/22 Cetaphil Daily cleanser) Use a small			
	amount as a facial cle	•			
	D : 0/40/04 /				
	Review on 2/19/24 of December 2023 throu revealed:	r client #1's MARs for ugh February 19, 2024			
		d as applied 7:00am and			
	7:00pm each day.				
	Observation on 2/19/sbin revealed:	24 of client #2's medication			
		spensed 4/26/22 with an			
	expiration date of 3/2				
	expiration date of 7/2	spensed 8/18/22 with an 7/23.			
	Attempted interview of unsuccessful because	on 2/20/24 with client #1 was e he declined to be			
	interviewed.				
	Interview on 2/22/24	with staff #1 revealed:			
	-Had administered Co				
	-Was not aware that				
		em (expired medications)			
	know that they have e	/, and let our supervisor expired."			
	Interview on 2/20/24				
	Professional revealed -Was not aware that 0				

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-"Usually they (staff) let me know if the med

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		MHL0601296	B. WING		02	2/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE		
BASS LA	NE GROUP HOME		SS LANE OTTE, NC 28270			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 119	(medication) is old ar They (medications) g	nd we properly dispose of it. go back to the pharmacy." ess to check for expired	V 119			
V 123	and significant adver reported immediately pharmacist. An entry and the drug reaction	9 MEDICATION . Drug administration errors se drug reactions shall be	V 123			
	facility failed to ensure errors were reported or pharmacist affecting findings are: Review on 2/19/24 arecord revealed: -Admission date of 1: -Diagnoses of Moder Developmental Disable Epilepsy12/8/23 Tretinoin (sl Apply small amount to	ew and interviews, the re medication administration immediately to a physician and 1 of 2 clients (#1). The and 2/20/24 of client #1's 2/1/14. The rate Intellectual collity, Cerebral Palsy, win treatment) 0.025% Cream				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPLE		E SURVEY PLETED
		MHL0601296	B. WING		02	2/22/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E. ZIP CODE	, ,	
		622 BAS		,		
BASS LA	NE GROUP HOME	CHARLO	TTE, NC 28270			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
V 123	Continued From page	e 7	V 123			
7 120	(ounce) Apply to left a daily for seven days.	arm and abdomen twice	V 120			
	revealed: -Tretinoin was not ap January 2024Eucerin Cream was	client #1's MARs for agh February 19, 2024 plied in December 2023 or documented as applied the ary 2024 and February 1-19,				
	Review on 2/20/24 of the facility's internal incident reports for the period of 12/1/23 to 2/18/24 revealed. -No documentation of contact to a physician or pharmacist when medication errors were made. Attempted interview on 2/20/24 with client #1 was					
	unsuccessful because interviewed.					
	-When a client missed supervisor immediate and contact the pharm reaction would be and and continue with the the back of the MAR.	with staff #1 revealed: d a medication, "I notify my ly and do an incident report macy and find out what d tell me if I skip that dose next dose. I would write on It was an oversight for me. more attention in the future."				
	to the pharmacist." -Did not contact the p discuss medication el Eucerin Cream. -Will contact a pharm	realed: iissed meds (medications) harmacist or physician to				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		MHL0601296	B. WING		02	/22/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
BASS LA	NE GROUP HOME		SS LANE OTTE, NC 28270			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 123	1 0	from the pharmacist or	V 123			

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