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

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 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BEAR CREEK	5840 GREENWOOD AVENUE LA GRANGE, NC 28551

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W 000	INITIAL COMMENTS A recertification and complaint survey was completed on 7/8/24 - 7/9/24 for intake #'s NC00217633, NC00217818 and NC00217578. The allegation was substantiated. A Condition of Participation in Health Care Services was cited; In addition, standard level deficiencies were also cited.	W 000		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that 2 of 10 audit clients (#6 and #9) was afforded privacy while receiving medications. The findings are: A. During afternoon observations of medication administration on 7/8/24 at 4:30pm, Nurse D went into classroom A and administered medications to client #9 via G-tube. Further observations revealed another client at the table along with direct care staff. At no time was client #9 afforded privacy during his medication administration. Interview on 7/9/24 with the ADON revealed that when medications are administered via G-tube, nurses should provide privacy by taking the client into the nurses station or their bedroom. The ADON confirmed that client #9 was not afforded privacy. B. During morning medication administration on 7/9/24, Nurse B went to the dining room table and	W 130		

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 130	Continued From page 1 administrated client #6 his sodium pill at 8:07am, while he was eating breakfast. Further observations revealed there were other clients at the table along with direct care staff. At no time was client #6 afforded privacy during his medication administration. During an immediate interview, Nurse B stated that client #6's sodium pill is written to be given with meals. Review on 7/9/24 revealed client #6's physician ordered stated his sodium pull is to be given with meals. During an interview on 7/9/24, the Assistant Director of Nursing (ADON) revealed client #6's sodium pill is to be given at meals. The ADON stated medications should either be given in client #6's bedroom or the medication room.	W 130		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to obtain initial evaluations for 3 of 8 newly admitted audit clients (#1, #6 and #8). The findings are: A. The facility failed to obtain initial evaluations within 30 days of admission for client #8. 1. Review on 7/8/24 of client #8's record revealed	W 210		

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W 210	Continued From page 2 she had not received her psychological evaluation. Further review revealed client #8 was admitted to the facility on 1/15/24. 2. Review on 7/8/24 of client #8's record revealed she had not received her vision evaluation. Further review revealed client #8 was admitted to the facility on 1/15/24. 3. Review on 7/8/24 of client #8's record revealed she had not received her audiological evaluation. Further review revealed client #8 was admitted to the facility on 1/15/24. B. The facility failed to obtain initial evaluations within 30 days of admission for clients #6. 1. Review on 7/8/24 of client #6's record revealed he had not received his vision evaluation. Further review revealed client #6 was admitted to the facility on 1/16/24. 2. Review on 7/8/24 of client #1's record revealed he had not received an auditory examination. Further review revealed client #1 was admitted to the facility on 3/28/24. C. Review on 7/8/24 of client #6's record revealed he had not received his vision evaluation. Further review revealed client #6 was admitted to the facility on 1/16/24. During an interview on 7/9/24, the Assistant Director of Nursing (ADON) confirmed client #8 had not received psychological, vision or audiological evaluation after admission, client #1 had not received vision and audiological evaluation after admission and client #6 had not received an evaluation for vision.	W 210		

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W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: The facility failed to: provide nursing services in accordance to client's needs (W331); train direct care staff in detecting signs and symptoms of illness (W342); keep all drugs locked except when being prepared for administration (W382) and provide dental examination annually (W352). The cumulative effects of these systemic practices resulted in the facility's failure to provide statutory mandated services in health care.	W 318		
W 331	NURSING SERVICES CFR(s): 483.460(c) 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 ensure clients were provided nursing services in accordance with their needs regarding timely and appropriate medical interventions for 2 of 10 audit clients (#4 and #10). The findings are: A. Nursing services failed to provide appropriate medical intervention prior to being admitted to the hospital. Record review on 7/8/24 of the facility's investigation summary dated 5/29/24 - 5/31/24 revealed that an investigation was conducted to determine the cause of client #4's swollen and	W 331		

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infected right index finger.

Review of the internal investigation revealed that on 5/27/24 during lunch at approximately 12:30pm, staff noted the client's right hand and index finger to be swollen and discolored. Nursing staff was notified and the medical provider was contacted. A T-Log entered by Nurse E revealed that the Physician Assistant (PA) was notified that the "right hand and index finger were swollen and bluish discoloration at the tip". Keflex 500mg twice daily was ordered and the first dose was given on 5/27/24 at 6:00pm.

Further review on 7/8/24 of the investigation revealed on 5/28/24, the PA physically assessed client #4 and ordered an x-ray. However, no documentation for the physical assessment could be located. X-ray results revealed extensive soft tissue edema with accompanying subcutaneous emphysema most consistent with infection. Further review of the investigation revealed the PA was notified of the x-ray results and informed that swelling was ascending upwards with client #4's fingers appearing to be tight and edematous. An order was received to send client #4 to the local emergency department (ED) for evaluation and treatment. A CT scan completed at the ED showed severe right forearm, wrist and hand soft tissue swelling, probable cellulitis and severe subcutaneous gas of the 2nd right digit suggesting gangrenous cellulitis. Additional testing suggested necrotizing fasciitis. Client #4 was admitted to the hospital and an incision and drainage procedure (I&D) was completed on 5/29/24. Additional treatment included surgical amputation of the right index finger on 5/31/24.

Review on 7/8/24 of client #4's medical records

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W 331	Continued From page 5 from the ED revealed a CT scan performed on 5/29/24 was compared to prior studies revealed subcutaneous emphysema has increased along the remainder of the second digit into soft tissues of the hand. The hospital was told that client #4 has a history of biting his nails and cuticles and it is believed that is how the infection entered the body. Clinical impression revealed diagnosis of necrotizing fasciitis, cellulitis and sepsis. Record review on 7/9/24 of the facility's body check forms that are to be completed daily on 1st and 2nd shift for client #4 from 5/24/24 - 5/29/24 revealed body checks completed on 5/24/24, 5/25/24, 5/26/24 and 1st shift on 5/27/24 "no tissue damage/injury". The body check completed on 5/28 for both 1st and 2nd shifts revealed "no tissue damage/injury". The body check on 5/29/24 for 1st shift revealed "no tissue damage/injury". It should be noted that client #4's injury was discovered on 5/27/24 and client #4 was later admitted to the hospital on 5/29/24. In addition, review of a written statement by staff revealed on 5/28/24 client #4's hand and arm could best be described as "Incredible Hulk" hand in appearance. Subsequent review on 7/8/24 of the internal investigation's recommended actions revealed that staff are to be in-serviced to ensure the proper reporting of any physical changes immediately to medical staff. Interview on 7/8/24 with the facility Administrator revealed that no in-service was completed following the incident with client #4 because there were no findings to indicate staff mishandled the situation. Further interview with the facility administrator regarding the staff's written	W 331		

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statements that Nurse E stated she wasn't sending the client out to the hospital due to it being a holiday. The administrator revealed that the facility was unable to prove she mismanaged the situation and believed she responded in a timely manner with relaying information to the PA.

A phone interview on 7/9/24 with the facility's PA revealed that he doesn't remember the exact course of events as it relates to client #4. The PA confirmed that nursing staff have a standing order to send clients out at anytime if they believe further services or treatments are needed immediately. The PA revealed he told the nurse that contacted him on 5/27/24 to send client #4 to the ED if he needed to go and is unsure why he wasn't sent out. The PA confirmed he did not document his physical assessment of client #4 on 5/28/24.

Nursing services failed to provide services in accordance to the clients needs in initiating timely and appropriate medical interventions.

B. Nursing services failed to provide needed services for client #4 upon returning to the facility.

Record review on 7/9/24 revealed client #4 was readmitted to the facility on 6/20/24 after being discharged from the hospital and spending time in a rehabilitation facility. Client #4 was ordered bandage changes on Monday's, Wednesday's, Friday's and as needed upon his return. On 6/27/24, client #4 had a follow-up appointment with the orthopedic and all bandages were discontinued.

Record review of the Electronic Medication Administration Record (EMAR) for client #4

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W 331	Continued From page 7 revealed dressing changes were completed on 6/24/24, 6/26/24, 6/28/24, 7/1/24 and 7/3/24 by nursing. Interview on 7/9/24 with the facility's Assistant Director of Nursing (ADON) confirmed dressings were discontinued on 6/27/24. The ADON confirmed dressing changes had been documented for the client in the EMAR after the order was discontinued and dressings were no longer supposed to be applied. Nursing failed to document accurately when dressing changes had been discontinued and no dressing was in place to be changed. C. Nursing services failed to provide foot/toenail care as needed. Interview on 7/8/24 with client #4's guardian revealed she was concerned that the client's toenails were long and dark in color. The guardian stated she brought it to the facility's attention while the client was hospitalized for amputation of his finger. Observations of client #4's foot on 7/9/24 revealed toenails were long and discolored. Interview with the ADON revealed nursing is responsible for foot/toenail care unless the client is diabetic. The ADON confirmed no records could be found of when foot/toenail care had been completed for client #4. However, she believed a referral had been made for him to see podiatry. Interview on 7/9/24 with the facility's infection control personnel confirmed no referral or	W 331		

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W 331	Continued From page 8 appointment had been made to podiatry for client #4. Phone interview with the facility's PA on 7/9/24 revealed he had not been made aware of any issues related to client #4's feet or toenails, nor had he been asked for a referral to podiatry to have his feet and toenails assessed. D. Nursing services failed to use adaptive equipment needed during medication pass. During afternoon medication administration observations on 7/8/24, Nurse A was observed handing a regular cup to client #10 to drink from. Client #10 refused to hold the cup on four attempts. Further observations revealed the Associate Professional obtained client #10's cup, which is a sippy cup. Additional observations revealed client #10 drank from the sippy cup without any issues. During an immediate interview, Nurse A revealed she was not aware client #10 utilized a sippy cup. During an interview on 7/9/24, the ADON stated the nursing staff have been informed about client #10's sippy cup that he utilizes during medication administration.	W 331		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for	W 342		

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W 342	Continued From page 9 accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were sufficiently trained in detecting signs and symptoms of illness and changes in client's health baseline. This affected 1 of 10 audit clients (#4). The finding is: Record review on 7/8/24 of the facility's investigative summary dated 5/29/24 - 5/31/24 revealed that an investigation was conducted to determine the cause of client #4's swollen and infected right index finger. Review of the internal investigation revealed that on 5/27/24 during lunch at approximately 12:30pm, staff noted the client's right hand and index finger to be swollen and discolored. Further record review on 7/9/24 of the facility's body check forms that are to be completed daily on 1st and 2nd shift for client #4 from 5/24/24 - 5/29/24 revealed body checks completed on 5/24/24, 5/25/24, 5/26/24 and 1st shift on 5/27/24 "no tissue damage/injury". The body check completed on 5/28 for both 1st and 2nd shifts revealed "no tissue damage/injury". The body check on 5/29/24 for 1st shift revealed "no tissue damage/injury". However, review of a written statement by staff revealed on 5/28/24 client #4's hand and arm could best be described as "Incredible Hulk" hand in appearance. Further review on 7/8/24 of the internal investigation's recommended actions revealed that staff are to be in-serviced to ensure the proper reporting of any physical changes immediately to medical staff.	W 342		

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W 342	Continued From page 10 Interview on 7/8/24 with the facility Administrator revealed that no in-service was completed following the incident with client #4 because there were no findings to indicate staff mishandled the situation, even though staff were not documenting the client's status appropriately and accurately during the infection, which resulted in the client's finger being amputated.	W 342		
W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2) Comprehensive dental diagnostic services include periodic examination and diagnosis performed at least annually. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client received comprehensive dental services including periodic examinations at least annually. This affected 1 of 10 audit clients (#4). The finding is: Review on 7/9/24 of client #4's record revealed his last dental examination and cleaning occurred on 2/3/23. No current dental examinations could be located. Interview on 7/9/24 with the Assistant Director of Nursing (ADON) confirmed client #4 is in need of a dental examination at this time.	W 352		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by:	W 382		

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W 382	Continued From page 11 Based on observations and interviews, the facility failed to ensure medications remained locked except when being prepared for administration. The findings are: A. During medication administration observations in the home on 7/8/24 at 4:55pm, Nurse A exited the medication room with a client. Further observations revealed medications had been left out on the medication cart. During an immediate interview, Nurse A revealed she had been trained not to leave the medications unattended. B. During medication administration observations in the home on 7/9/24 at 7:43am, Nurse B exited the medication room with a client. Further observations revealed medications had been left out on the desk. During an immediate interview, Nurse B revealed she had been trained not to leave the medications unattended. During an interview on 7/9/24, the Assistant Director of Nursing (ADON) stated medications should never be left unattended.	W 382		