STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G229	A. BUILDING _____ B. WING _____	06/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD	554 RIDGE LANE WILKESBORO, NC 28697

(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 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on facility document review and interview, the facility failed to ensure all allegations of potential abuse/neglect were reported to the administrator immediately for 1 of 1 investigations reviewed. The finding is: Review of the facility's abuse/neglect investigations on 6/5/18 revealed an investigation started on 10/10/17 and completed on 10/13/17. Review of the investigation revealed on 10/10/17 at 4:30 PM, the qualified intellectual disabilities professional (QIDP) received a call from the local department of social services (DSS) advising they had started an abuse allegation investigation because they had received a report of staff to client physical abuse. Continued review of the facility investigation revealed the facility started an investigation on 10/10/17 to determine if Staff A and/or Staff B had pinched or pulled the hair of client #1. Further review of the facility investigation revealed DSS received a report related to Staff A abusing client #1 and during the process of the facility investigation another allegation developed related to Staff B abusing client #1. Both staff members were suspended immediately. The facility investigation did not result in a finding of abuse or mistreatment.	W 153		

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

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W 153	Continued From page 1 Continued review of the facility investigation documentation revealed an incident/accident report completed on 10/10/18 for an incident which occurred on 10/9/18 at 7:00 AM. The incident/accident report indicated that while assisting client #1 with bathing and dressing, a direct care staff person discovered a bruising on client #1's upper right arm. The report documentation revealed the direct care staff person asked the client how the bruising occurred and the client indicated "staff did it, but gave no name." Continued review of the report documentation revealed the home manager was notified on 10/9/18 and no other staff notifications were documented. Interview with the qualified intellectual disabilities professional and the facility administrator on 6/6/14 confirmed they were first made aware of the allegation when DSS called the facility to report the start of their investigation. Therefore, the staff failed to immediately report an allegation of abuse to the facility administrator resulting in a one day delay in the start of the investigation.	W 153		
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 observation, facility document review and interview, nursing services failed to assure staff were adequately trained to notify nursing of client incidents/injuries in a timely manner for 2 of 3 sampled clients (#1 and #6). The findings are:	W 331		

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W 331	Continued From page 2 A. Nursing services failed to assure direct care staff were adequately trained to notify nursing of a bruised area for client #1. Examples include: Review of facility incident reports on 6/5/18 revealed an incident report completed on 10/10/17 for bruising on client #1's upper right arm which was discovered on 10/9/17 at 7:00 AM. Review of the incident/accident report documentation revealed direct care staff discovered the bruising while assisting the client with bathing/dressing. Continued review of the incident report did not indicate nursing services was notified until 10/10/17. Further review of the report revealed nursing assessed the client on 10/10/17 and the nursing documentation indicated two small bruises on the client's upper right arm area. This incident report was also included as part of a facility abuse/neglect investigation documentation. Interview with nursing staff on 6/6/18 confirmed that nursing services was not notified of this injury until 10/10/18 and confirmed group home staff should have notified nursing services immediately following the discovery of the injury. B. Nursing services failed to assure direct care staff were adequately trained to notify nursing of an incident with potential injury for client #6. Observations conducted on 6/5/18 at 4:45 PM revealed client #6 was seated at a table on the outdoor patio of the home. Continued observations revealed client #6 completed a craft project which included painting a wooden "tulip". Client #6 was subsequently observed to take the tulip to place it in the yard of the home, accompanied by staff holding his gait belt. Client	W 331		

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W 331	Continued From page 3 #6 was then observed to drop forcefully to his knees on the concrete patio while placing the wooding tulip in an adjacent flower bed. Interview conducted on 6/6/18 with the nurse revealed client #6 has been identified as having an increased risk of falls for which the use of a gait belt has been implemented. Further interview with the nurse revealed no notification or written documentation had been received regarding the incident which occurred on 6/5/18 during which client #6 dropped to his knees on the patio. Continued interview with the nurse verified all incidents involving falls and/or actual or potential injury to client #6 should be documented and reported to the nurse.	W 331		
W 373	DRUG ADMINISTRATION CFR(s): 483.460(k)(6) The system for drug administration must assure that no client self-administers medication until he or she demonstrates the competency to do so. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for drug administration failed to assure 1 of 3 sampled clients did not self-administer medication until demonstrating the competency to do so (client #5). The finding is: Observations conducted on 6/6/18 at 8:15 AM revealed client #5 emerging from the medication administration area carrying a plastic medication cup containing a liquid substance in her hand. Client #5 was then observed to walk unsupervised toward her bedroom with the cup and immediately return to the living room of the	W 373		

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W 373	Continued From page 4	W 373		

home and toss the cup into the trash. Staff was then observed to ask client #5 what happened to the medication in the cup and client #5 stated she had spilled it in her bedroom. Staff was then observed to enter client #5's bedroom and state they were unable to locate a spill, however, staff stated client #5's toothbrush was found in the trash receptacle in her bedroom. Interview with direct care staff at that time revealed the liquid substance in the medication cup was Peridex (Chlorhexidine glucconate) solution that client #5 had been given by staff administering medications to brush her teeth with. Subsequent observations at 8:20 AM revealed the home manager replaced the Chlorhexidine glucconate solution and toothbrush for client #5 and accompanied client #5 to the bathroom to brush her teeth.

Review of the record for client #5, conducted on 6/6/18, revealed physician's orders dated 4/10/18 documenting client #5 was to receive Chlorhexidine glucconate 0.12% - brush to teeth twice daily for gingivitis. Further review of the record for client #5 revealed a person centered plan (PCP) dated 2/23/18 which included training objectives for client #5 including: fill out a check, improve work behaviors, make bed, rinse hair, ensure privacy and decrease target behaviors. Continued review of the 2/23/18 PCP revealed an adaptive behavior inventory (ABI) dated 1/17/18 which documented client #5 demonstrated no independence to partial independence in any area of self-administration of medications.

Interview with the home manager present in the home throughout survey observations on the morning of 6/6/18 verified client #5 had been provided with the liquid medication in the cup

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W 373	Continued From page 5 which was identified as Peridex (Chlorhexidine glucconate) solution by direct care staff administering medications, and given instruction to take the Peridex to the bathroom and brush her teeth with it. Interview conducted with the nurse on 6/6/18 at 11:30 AM further verified client #5 had a current physician's order for Chlorhexidine glucconate 0.12% to brush her teeth with twice daily. This interview further revealed client #5 had not demonstrated competency in self-administration of medications. This interview further verified staff administering medications should supervise and assist client #5 during all aspects of medication administration.	W 373		