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 _____	06/09/2021

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 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the team failed to assure techniques to manage inappropriate behavior were not used as a substitute for active treatment for 6 of 6 clients (#1, #2, #3, #4, #5 and #6) relative to television remote access. The finding is: Observations during the 6/8-9/21 survey revealed a television in the living room that various clients at various times were observed to sit in the living room and watch. Continued observation of the living room area on 6/8-9/21 revealed no remote control to the television. Further observation on 6/9/21 at 8:10 AM revealed staff B to remove a television remote from the kitchen cabinet and to enter the living room where client #4 was watching television. Subsequent observation revealed staff B to change the television channel and to engage client #4 in a preferred channel selection. Additional observation revealed staff B to return the television remote to the kitchen cabinet after assisting client #4 with identifying a preferred channel. Interview with staff A on 6/9/21 revealed the television remote is kept in the kitchen cabinet due to behaviors of some clients with breaking, losing or hiding the remote control. Continued	W 288		

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

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W 288	Continued From page 1 interview with staff A verified clients #1, #2 and #4 did not have personal televisions in their bedroom and were dependent on the living room television to have the ability to watch television. Interview with the facility qualified intellectual disabilities professional (QIDP) on 6/9/21 verified the remote control to the group home living room television should not be kept in the kitchen cabinet.	W 288		
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: Based on observations and interview, the facility failed to keep a prescription topical locked for 1 of 3 sampled clients residing in the facility (#3). The finding is: Observation in the group home on 6/9/21 at 7:55 AM revealed staff A to enter the bedroom of client #3 and to exit with the client's shower box that was taken to a hallway bathroom. Continued observation revealed staff A to leave client #3's shower box unattended in the bathroom, with the bathroom door open, and to return to client #3's room. Observation of the contents of client #3's shower box revealed a bottle of shampoo with a prescription label. Subsequent observation revealed the bathroom door to remain open and client #3's shower box to sit unattended from 7:59 AM until 8:04 AM. Review of records for client #3 on 6/9/21 revealed physician orders dated 5/26/21. Continued	W 382		

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W 382	Continued From page 2 review of the current physician orders for client #3 revealed an order for Ketoconazole 2% shampoo with the directive to apply to scalp, leave on 5 minutes before washing; 3 times weekly. Interview with staff A on 6/9/21 verified client #3 has a prescribed shampoo that is kept in the client's shower box. Continued interview with staff A revealed staff are allowed to store medicated shampoo in the client's shower box because it is a shampoo and used during showers. Interview with the facility nurse on 6/9/21 revealed client #3's prescribed shampoo should not be kept in the clients shower box and should not be left unattended. Continued interview with the facility nurse verified a prescription strength shampoo should be kept locked in the medication room and the medication record should be signed when staff administer the shampoo.	W 382		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide teaching relative to eyeglasses for 1 of 3 sampled clients (#5). The finding is:	W 436		

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W 436	Continued From page 3	W 436		

Observation in the group home throughout the 6/8-9/21 survey revealed client #5 to participate in various activities to include: leisure activities at the dining table, setting the table for the dinner meal, meal participation, household chores and medication administration. Continued observations throughout the 6/8-9/21 survey revealed client #5 to participate in activities without the use of eyeglasses. Subsequent observation revealed no prompts or direction from staff for client #5 to wear eyeglasses.

Review of records for client #5 on 6/9/21 revealed a person centered plan (PCP) dated 12/16/20 with training objectives relative to learning to use a check register, make bed, privacy, brush teeth and wash hands. Continued review of records for client #5 revealed a behavior plan for target behaviors of physical aggression, taking items that belong to others, food snatching, verbal aggression, false accusations, un-cooperation, inappropriate touch, property destruction, hyperactive behavior and depressed behavior. Property destruction was defined as throwing items, breaking items, hitting/kicking items or any other attempt to destroy the environment.

Review of a vision consult for client #5 dated 5/7/19 revealed a diagnosis of myopia and astigmatism. Further review of the current vision consult revealed the recommendation to initiate glasses to improve vision.

Interview with client #5 on 6/8/21 revealed she had broke her eyeglasses and had new glasses on order. Interview with facility staff verified client #5 had broken her eyeglasses in her sleep and new eyewear had been ordered. Continued interview with facility staff verified client #5 has a

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W 436	Continued From page 4 history of breaking her eyeglasses as she will throw them, sleep in them and is really rough with care. Interview with the facility qualified intellectual disabilities professional (QIDP) verified client #5 has a history of breaking her eyeglasses due to improper care. Continued interview with the QIDP verified client #5 did not have a training objective to address proper care of eyeglasses. Subsequent interview with the QIDP revealed client #5 could benefit from a program to address proper care of her eyewear and it was unknown why a program had not been implemented.	W 436		