STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G129	A. BUILDING ______ B. WING ______	07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WAKULLA I & II	**5792 & 5812 NC HWY 71 NORTH MAXTON, NC 28364**

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, policy and interviews, the governing body and management failed to exercise general policy and operating direction over the facility, to protect the clients from potential hazards by failing to ensure chemical products were kept locked and inaccessible to clients. This had the potential to affect all six clients (#1, #2, #3, #4, #5 and #6) in the home. The finding is: During observations in Wakulla I on 7/6/21 at 11:30 am, 4 bottom kitchen cabinets doors, in proximity to the kitchen sink were missing. Directly under the sink were a gallon container of bleach and liquid dishwasher detergent. In the second cabinet next to the sink were: 13 bottles of liquid chemical cleaning products 2 cans of Oven Cleaner Large Bottle of Bleach Wipes Additional observations during the survey 7/6/21-7/7/21 revealed that at mealtimes, all the clients were unsupervised in the kitchen when discarding trash or loading the dishwasher. All of the clients had the ability to access the chemical products that were left exposed in bottom cabinets without doors. Review of the facility's Safety and Health Policy and Procedures Manual on chemical storage	W 104	DHSR - Mental Health JUL 30 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Herring
TITLE: Vice President of Operations
(X6) DATE: 7/27/2021

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 104	Continued From page 1 guidelines from the Center of Disease Control (CDC) dated March 2018 said: "Store highly toxic or controlled materials in a locked, dedicated poison cabinet." Review of the facility's work order, dated 6/16/21 revealed a request to replace the kitchen cabinets due to Client #2's behavior. An interview on 7/7/21 with Staff C revealed that Client #2 would go into a rage and destroy property. Staff C said that Client #2 had ripped the kitchen cabinets from the hinges about a month ago. An interview on 7/7/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that a month ago the cabinet doors were ripped off. Maintenance made repairs and three days later Client #2 damaged the cabinets again. The QIDP commented that Client #2 did not like cabinets and had damaged cabinets in her bedroom and bathroom. A follow up interview on 7/7/21 the QIDP informed the surveyor that the chemicals had been removed from the two kitchen cabinets and moved to an unlocked utility closet on an upper shelf.	W 104		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.	W 137		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G129	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED 07/07/2021

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W 137	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to grant access to pantry for all clients (#1, #2, #3, #4, #5 and #6). The finding is: During observations in Wakulla I on 7/6/21 at 4:00 pm, Staff A took a key out of her pocket and unlocked the door to the pantry to retrieve a food item. An additional observation on 7/7/21 at 6:40 am revealed that Staff B used a key that she carried in her pocket to unlock the pantry door. When asked why the door was kept locked, Staff B pointed at Client #5, with no explanation. An interview on 7/7/21 with Staff E revealed that the pantry has always been kept locked and that only the staff had keys to unlock it. An interview on 7/7/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that the pantry should be kept unlocked unless there was an issue with food stealing by a client in the home and she was not aware of it being an issue. The QIDP revealed that after further discussion from staff, the pantry door was kept locked from past events in the home, with a former client. Also, the pantry door was kept locked because Client #5 had demonstrated self-injurious behaviors a few months ago and the knives needed to be kept in a secure location. The QIDP indicated that if the pantry door needed to be locked, then the clients who did not have restrictive access to knives, should have received their own keys to access the pantry.	W 137		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe	W 240		

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W 240	Continued From page 3 relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #6's Individual Program Plan (IPP) included relevant interventions to support her toward independence during dining. This affected 1 of 4 audit clients. The finding is: During 3 of 3 meal observations in Wakulla II on 7/6 - 7/7/21, client #6 refused to eat her food. At all meals, various staff provided verbal and physical prompts to encourage the client to consume her food. Client #6 continued to refuse. After dinner, the client was given an Ensure supplement which she consumed. No other food choices or supplements were offered. Interview on 7/6/21 with Staff J revealed client #6 does refuse at times but will feed herself when she is hungry. Interview on 7/7/21 with Staff N indicated when client #6 refuses to eat they "try to talk to her" and just save her food and ask her later. Review on 7/7/21 of client #6's IPP dated 1/12/21 revealed no information regarding her meal refusals or interventions for staff to support her during dining. Interview on 7/7/21 with the facility's nurse indicated all clients who refuse a meal have the option of consuming a dietary supplement. Interview on 7/7/21 with the Qualified Intellectual	W 240		

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W 240	Continued From page 4 Disabilities Professional (QIDP) revealed client #6 does refuse to eat at times. Additional interview did not indicate any information was included in the client's IPP to address meal refusals.	W 240		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of dining skills, positioning, and meal guidelines. This affected 2 of 4 audit clients (#6 and #11). The findings are: A. Client #11's meal guidelines were not implemented as indicated. During 3 of 3 meal observations in Wakulla II during the survey on 7/6 - 7/7/21, client #11 consumed his food quickly and took infrequent sips of his drink. The client was assisted to serve his food along with other clients, received full servings of all food items on his plate and used a spoon at all meals. At the meals, client #11	W 249		

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W 249	Continued From page 5 received zero to two prompts from staff to slow down or to take sips of his drinks. Interview on 7/7/21 with Staff N revealed client #11 does not have any specific guidelines they follow at meals other than to prompt him slow down and to drink "every so often". Review on 7/6/21 of client #11's IPP dated 9/14/20 revealed, "It is suggested that staff place 1/2 of the amounts of three foods on his plate in each of the three sections. Staff is to spread the foods out thinly. Staff should frequently ask [Client #11] to slow down while he is eating...After several bites of food (2 - 3) staff should ask him to take a drink...[Client #11] needs continual supervision during meals...Staff should encourage fork use also." Interview on 7/7/21 with the Qualified Intellectual Disabilities Professional (QIDP) indicated the meal guidelines should have carried over from his move into the home back in February. B. During 3 of 3 meal observations in Wakulla II during the survey on 7/6 - 7/7/21, client #11 utilized a regular spoon without a thicken handle. At lunch and breakfast, the client consumed his food from a sectioned plate. A dycem mat was provided at all meals. Interview on 7/6/21 with Staff J revealed client #11 utilizes an adaptive plate at meals. The staff did not identify any other adaptive dining equipment. Review on 7/6/21 of client #11's IPP dated 9/14/20 revealed, "[Client #11] uses a high sided ream and slope plate, and small regular utensils	W 249		

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W 249	Continued From page 6 with thicken handle when eating and a dycem mat...Staff should encourage fork use also." Interview on 7/7/21 with the QIDP confirmed client #11 should utilize the identified adaptive dining equipment at meals. C. During observations throughout the survey in Wakulla II on 7/6 - 7/7/21, client #11's feet and ankles were swollen. The client's legs/feet were not observed to be elevated during the survey. Interview on 7/7/21 with Staff N confirmed client #11's feet/ankles were swollen. Additonal interview indicated the client elevates his feet in the mornings if they do not go anywhere, after lunch and on second shift. Review on 7/6/21 of client #11's IPP dated 9/14/20 revealed, "Staff should encourage keeping feet raised (propped on a chair or leg rests) when sitting to assist with edema reduction..." Additional review of the client's fall prevention and safety guidelines dated 3/2/21 noted, "Encourage [Client #11] to elevate his feet/legs when sitting. Encourage him to spend some time in his recliner with feet elevated." Interview on 7/7/21 confirmed client #11 should be utilizing a Geri chair in the home to elevate his feet. Additional interview noted he needs prompts and assistance from staff to elevate his feet. D. During dinner and breakfast observations in Wakulla II on 7/6 - 7/7/21, staff served food items onto client #6's plate and poured her drinks without prompting or encouraging her to participate with these tasks.	W 249		

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W 249	Continued From page 7	W 249		

Continued From page 7

Interview on 7/6/21 with Staff J revealed "She won't do it" when asked if client #6 can assist with serving herself or pouring her drinks at meals.

Review on 7/7/21 of client #6's IPP dated 1/12/21 indicated, "[Client #6] can pour her own water... [Client #6] likes to participate in family style dining." Additional review of the client's Adaptive Behavior Inventory (ABI) updated 1/2021 noted she can serve herself from a bowl/platter and pour from a small pitcher with partial independence. Further review of client #6's Mealtime/Feeding Guidelines (OSG #8) dated 3/19/20 revealed, "Assist [Client #6] with serving her meals and provide assistance with pouring drinks."

Interview on 7/7/21 with the QIDP confirmed the client's mealtime guidelines were current and should be followed.

E. During observations throughout the survey in Wakulla II on 7/6 - 7/7/21, client #6 was seated in her wheelchair. The client was not provided alternative positioning during the observations.

Interview on 7/7/21 with Staff N indicated guidelines provided by the Physical Therapist (PT) are implemented by staff.

Review on 7/7/21 of client #6's record revealed a Changing Positioning Schedule (implemented 7/5/18) revealed, "The purpose of this program is to ensure [Client #6] has the opportunity to change her position throughout the day at the Vocational center or at the home. This changing in positioning schedule will include changing positioning from wheelchair to regular chair or

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W 249	Continued From page 8 Geri chair and back to he wheelchair." Interview on 7/7/21 with the QIDP confirmed staff should be offering client #6 alternative positioning from her wheelchair which could include a regular chair with side arms, the Geri chair or the couch.	W 249		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received their specially-prescribed diets as indicated. This affected 2 of 4 audit clients (#6 and #11). The findings are: A. During dinner observations in Wakulla II on 7/6/21, staff placed ground beef, a soft taco shell, shredded cheese, sour cream, shredded lettuce, chopped tomatoes and milk in a food processor and blended the items together. After blending, the beef mixture was served to client #6. The food was thick and lumpy with visible pieces of meat. Client #6 did not consume the meal. Interview on 7/6/21 with Staff H revealed client #6 consumes a pureed diet. Additional interview on 7/7/21 with Staff N indicated pureed food should look "like applesauce". Review of a food consistencies chart posted in the kitchen of the home indicated, "Pureed food should be smooth with no lumps."	W 460		

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W 460	Continued From page 9 Review on 7/6/21 of client #6's Individual Program Plan (IPP) dated 1/12/21 and a diet list dated 9/3/20 posted in the kitchen of the home revealed the client consumes a regular, pureed food diet. Interview via phone on 7/7/21 with the dietitian confirmed pureed food should be "smooth and creamy". B. During breakfast observations in Wakulla II on 7/7/21, client #11 was assisted to serve himself pureed eggs and waffles. The client consumed the food items without difficulty. Interview on 7/6/21 with Staff H revealed client #11 consumes a ground diet. Review of a food consistencies chart posted in the kitchen of the home indicated, "Ground food should be about the size of a grain of rice." Review on 7/6/21 of client #11's IPP dated 9/14/20 and a diet list dated 9/3/20 posted in the kitchen of the home revealed the client consumes a ground food diet. Interview on 7/7/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #11 consumes a ground.	W 460		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by:	W 473		

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W 473	Continued From page 10 Based on observations, record review and interviews, the facility failed to ensure all foods were served at an appropriate temperature. The finding is: During meal preparation observations in Wakulla II on 7/7/21, the waffles were removed from the oven at 7:12am while the scrambled eggs were removed from the pan at 7:21am. Staff N pureed the waffles and then the eggs, adding water to both. Clients began consuming the food at 7:42am. The temperature of the pureed waffles and eggs was not taken and the food was not reheated. Interview on 7/7/21 with Staff N revealed she does not usually take the temperature of foods and does not know what food temperatures should be. Additional interview indicated she thought a food temperature chart was posted in the kitchen. Review on 7/7/21 of the facility's menu book located in the kitchen of the home revealed "All hot food and beverages must be held at 140 or higher...Items taken from heat keeping and/or cold keeping devices they must be served to clients within 15 minutes or reheated to 165, then served." During an interview on 7/7/21, the Qualified Intellectual Disabilities Professional (QIDP) acknowledged pureed foods lose their temperature quickly and need to be reheated.	W 473		

W 104

The Interdisciplinary Team met and agreed that the maintenance department will install a cabinet in the supply closet with a lock on only the cabinet to hold chemical supplies.

Maintenance Dept. will label the cabinet Poison cabinet. The key to the cabinet will be placed on the house ring for all Individuals to have access to it with staff supervision when in use.

Home Manager will In-service all staff on securing chemicals. Monitoring will occur thru direct observation by QP, Home Manager and Nursing weekly until situation resolved.

Target date: 9/13/2021

W 137

Home Manager will inservice staff that the pantry door should be kept unlocked at all times.
Home Manager will purchase a lock box to store knives. The box will be locked and stored in the supply closet. The key to the locked box will be placed on the house ring for all Individuals to have access to it with staff supervision when in use.

Home Manager will In-service all staff on securing knives. Monitoring will occur thru direct observation by QP, Home Manager and Behavior Analyst weekly until situation resolved.

Target date: 9/13/2021

W 240

IDT Team members met and agreed that for meal refusals for client #6 and all other clients
Nursing will obtain a doctor orders to offer client #6 and all other clients a substitute first and if they refuse the substitute they should be offered a supplement.

QP will update Client #6 PCP to include meal refusals information. Substitutions or supplements will be documented on substitution sheets.

Weekly mealtime observations will be conducted by the clinical team members until situation has resolved.

Target Date: 9/13/2021

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W 249

A. & B.
Occupational Therapist will update client # 11 Mealtime Guidelines. OT will address client #11 mealtime adaptive equipment in the guidelines. Staff will be Inserviced on the new guidelines by OT/PT assistant.

Mealtime assessments will be conducted weekly by the clinical team until situation has resolved.

Target date: 9/13/2021

C
Physical Therapist will update current fall prevention and safety guidelines for client #11. OT will ensure all clients Fall Prevention and safety Guidelines are current.

Staff will be Inserviced on the new guidelines by OT/PT assistant. Interaction assessments will be conducted weekly by the clinical team until situation has resolved.

Target date: 9/13/2021

D.
Hab. Spec. will update the Adaptive Behavior Inventory for client #6 and ensure that all other clients ABI's are updated.

Occupational Therapist will assess and update client #6 meal-time guideline (OSG#8) and ensure all other guidelines are current to meet needs.

Staff will be inserviced on new guidelines by OT/PT assist.
QP will update client #6 PCP.

Monitoring will occur weekly with mealtime assessments by the clinical team until situation has resolved.

Target date: 9/13/2021

E.
PT will be asked to update repositioning schedule for client #6 and all other repositioning schedules for the Wakulla II clients.

OT/PT Assist. will inservice updated schedule to staff.

Monitoring will occur bi-weekly with interaction assessments by the clinical team until situation has resolved.

Target date: 9/13/2021

W 460

A. & B
The Dietician will be asked to provide food consistency training, diet training for Client # 6 and #11, as well as, all clients at the Wakulla II home.

The Dietician will inservice staff at the next scheduled house meeting with additional training if needed.

Monitoring will occur weekly with mealtime assessments by the clinical team until situation has resolved.

Target date: 9/13/2021

W 473
The Dietician will be asked to provide informal food temperature training for all the clients at the Wakulla II home.

The Dietician will inservice staff at the next scheduled house meeting with additional training if needed.
Monitoring will occur weekly with mealtime assessments by the clinical team until situation has resolved.

Target date: 9/13/2021

July 27, 2021

Mental Health Licensure and Certification Section
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Wakulla I & II 5792 & 5812 NC HWY 71 N, Maxton, NC 28364
Provider Number 34G129
MHL Number : MHL078-029
Email Address: jherring@rhanet.org

DHSR - Mental Health

JUL 30 2021

Lic. & Cert. Section

Mrs. Wilma I. Worsley-Diggs

Enclosed is a copy of the Plan of Correction of the survey that was conducted at the Wakulla I & II 5792 & 5812 NC HWY 71 N, Maxton, NC 28364 on July 7, 2021

If there are any questions, please feel free to call Mrs. Jan Herring or Deloris Monroe, QP at (910) 844-9664.

Sincerely,

Jan Herring, Vice President