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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 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. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure client #4 had the right to access to her personal grooming supplies. This affected 1 of 7 audit clients. The finding is: During observations in Wakulla I on 8/8/23, client #4's grooming bin containing various personal hygiene items was locked in a supply closet in the home. Client #4 did not have access to her personal grooming items. Interview on 8/8/23 with Staff C and Staff D revealed they did not know why client #4's grooming bin was located in the supply closet. Review on 8/8/23 of client #4's Adaptive Behavior Inventory (ABI) dated June 2023 revealed total independence regarding her access to grooming supplies. Interview on 8/8/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she was not sure why client #4's grooming supply bin was in the locked closet.	W 137		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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

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W 189	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained to assist client #5 to use his helmet appropriately as needed. This affected 1 of 7 audit clients. The finding is: During observations in Wakulla II on 8/7//23 from 3:45pm - 6:00pm, client #5 frequently walked around the home with staff assistance using the client's gait belt. Although staff ensured client #5 had his helmet on, at no time was the helmet strap fastened. Further observations in the home on 8/8/23 from 6:30am - 8:30am, client #5 consistently walked to various areas of the home with staff assistance using the client's gait belt. Although client #5 had his helmet on, at no time was the helmet strap fastened. Review on 8/8/23 of client #5's Occupational Therapy evaluation dated 2/13/23 revealed client #5 wears a helmet while transferring, walking, toileting and showering. Interview on 8/8/23 with the home manager confirmed client #5's helmet should be fastened around his chin when ambulating in the home.	W 189		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the	W 240		

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W 240	Continued From page 2 Individual Program Plan (IPP) for 2 of 7 audit clients (#4 and #9) included specific information to support their independence. The findings are: A. During observations in Wakulla I throughout the survey on 8/7 - 8/8/23, the door to the food pantry was kept locked. Various staff utilized a key to unlock the pantry to obtain food items. Although client #9 was in the kitchen assisting with meal preparation tasks for dinner on 8/7/23 and for breakfast on 8/8/23, the client was not prompted or assisted to use a key to unlock the pantry. Interview on 8/8/23 with Staff C revealed all of the clients in the home can use a key. Review on 8/8/23 of client #9's Adaptive Behavior Inventory dated July 2023 indicated "NA" under using a key. Additional review of the client's IPP dated 3/7/23 did not include any information regarding her ability to utilize a key or the supports needed to do so. Interview on 8/8/23 with the Qualified Intellectual Disabilties Professional (QiDP) revealed she was not sure if client #9 knows how to use a key but felt she probably could. B. During 2 of 3 mealtime observations in Wakulla I throughout the survey on 8/7 - 8/8/23, various staff cleared client #4's dishes after meals without prompting or assisting her to participate with this task. Interview on 8/8/23 with Staff C indicated client #4 was not allowed to carry her dishes into the kitchen after meals due to issues with her gait.	W 240		

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W 240	Continued From page 3 Review on 8/8/23 of client #4's IPP did not include information to support the client with clearing her dishes after meals. Interview on 8/8/23 with the QIDP confirmed client #4 should not ambulate to clear her dishes; however, her IPP did not indicate supports necessary to assist the client to clear her dishes without ambulating.	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 review and interviews, the facility failed to ensure 1 of 7 audit clients (#11) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program implementation regarding the use of elbow protectors. The finding is: During observations at the day program and in Wakulla II on 8/7/23, at no time was client #11 observed to be wearing elbow protectors. Further observations in the home on 8/8/23	W 249		

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W 249	Continued From page 4 revealed at no time was client #11 observed to be wearing elbow protectors. Review on 8/7/23 of client #11's Individual Program Plan (IPP) dated 9/6/22 revealed client #5 is to wear elbow protectors on both arms anytime he is up and in his wheelchair or other chair. Interview on 8/8/23 with the home manager revealed client #11 is supposed to wear elbow protectors when he is in his wheelchair. Interview on 8/8/23 with the qualified intellectual disabilities professional (QIDP) confirmed client #11 should have had elbow protectors on while in his wheelchair or any other chair.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure data relative to the accomplishment of criteria specified in the Individual Program Plan (IPP) was documented in measurable terms. This affected 1 of 7 audit clients (#8). The finding is: During observations at the day program and in Wakulla I throughout the survey on 8/7 - 8/8/23, client #8 wore a soft helmet. During evening	W 252		

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W 252	Continued From page 5 observations in the home on 8/7/23 from 3:45pm - 6:30pm, client #8 wore the helmet continuously except on two occasions when it was removed while on the patio and during dinner. Upon arrival to the home on 8/8/23 at 6:25am, client #8 was observed wearing the helmet while seated on the couch. At 7:45am, Staff D removed the helmet at the breakfast meal. Interview on 8/8/23 with Staff D revealed the use of client #8's is documented on specific sheets located in the home. Review on 8/8/23 of client #8's IPP dated 4/4/23 revealed the client wears a restrictive helmet. Additional review of the client's training book indicated the helmet's use (on/off) should be documented including circulation checks. Further review of documentation sheets for the helmet's use revealed no documentation on 8/7/23 from 3:30pm - 10:50pm (2nd shift) and missing documentation on 8/8/23 from 4:00am - 7:00am (3rd shift). Interview on 8/8/23 with the Qualified Intellectual Disabilites Professional (QIDP) confirmed client #8's helmet use should be documented as indicated.	W 252		
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	W 288		

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W 288	Continued From page 6	W 288		

interviews, the facility failed to ensure techniques to manage client #9's inappropriate behaviors were included in a formal active treatment program. This affected 1 of 7 audit clients. The findings are:

A. During observations in Wakulla I on 8/8/23, client #9's grooming bin containing her personal hygiene supplies was kept in a locked supply closet in the home.

Interview on 8/8/23 with Staff C revealed client #4's grooming bin is kept in the supply closet because she will throw the items out of the bin if it is kept in her bedroom.

Review on 8/8/23 of client #9's Adaptive Behavior Inventory (ABI) dated July 2023 indicated she has total independence regarding access to her grooming supplies. Additional review of the client's Behavior Support Plan (BSP} dated 6/2/23 revealed an objective to address severe disruption, aggression, self-injurious behavior, and property damage with no restrictions of grooming supplies noted. Further review of the record did not include a formal active treatment program to address restricting the client's access to her grooming supplies.

Interview on 8/8/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed locking away client #9's personal hygiene items was not included in a formal active treatment program.

B. During observations in Wakulla I throughout the survey on 8/7 - 8/8/23, the door to the food pantry was kept locked. Various staff utilized a key to unlock the pantry to obtain food items.

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W 288	Continued From page 7 Interview on 8/8/23 with Staff C revealed the pantry is locked due to client #9's behaviors. Review on 8/8/23 of client #9's Behavior Support Plan (BSP} dated 6/2/23 revealed an objective to address severe disruption, aggression, self-injurious behavior, and property damage. The BSP did not indicate the food pantry should be locked to address client #9's inappropriate behaviors. Additional review of the record did not include a formal active treatment program to address restricting client #9's access to the food pantry. Interview on 8/8/23 with the Behavior Specialist confirmed client #9 will go in the pantry and take food; however, the food pantry should not be locked to address her inappropriate behavior.	W 288		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 2 of 4 clients (#4 and #9) observed receiving medications in Wakulla I. The findings are: A. During morning observations in Wakulla I on 8/8/23 at 6:31am, the 3rd shift Medication Technician (MT1) assisted client #9 to administer one spray of Flonase 50mcg into both nostrils. The bottle of Flonase was not shaken prior to administration.	W 368		

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W 368	Continued From page 8 Review on 8/8/23 of client #9's physician's orders dated 6/8/23 revealed an order for Flonase 50mcg, one spray into each nostril twice daily for allergies at 7a and 8p. The order noted, "Shake Well." B. During additional observations in the home on 8/8/23 at 6:36am, the MT1 assisted client #4 to administer one spray of Flonase 50mcg into both nostrils. The bottle of Flonase was not shaken prior to administration. Review on 8/8/23 of client #4's physician's orders dated 6/8/23 revealed an order for Flonase 50mcg, one spray into each nostril twice daily for allergies at 7a and 8p. The order noted, "Shake Well." Interview on 8/8/23 with the facility's nurse confirmed the Flonase should be shaken prior to administration per physician's orders as the contents may have settled.	W 368		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 4 clients (#9) observed receiving medications in Wakulla I. The finding is: During morning observations in Wakulla I on 8/8/23 at 6:31am, the 3rd shift Medication	W 369		

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W 369	Continued From page 9 Technician (MT1) assisted client #9 to administer one spray of Flonase 50mcg into both nostrils. During additional observations in the home on 8/8/23 at 7:56am, the first shift Medication Technician (MT2) assisted client #9 to administer one spray of Flonase 50mcg into both nostrils. Immediate Interview with the MT2 revealed client #9 should not have been administered her Flonase by the 3rd shift MT and the Flonase was ordered for 8:00am. Review on 8/8/23 of client #9's physician's orders dated 6/8/23 revealed an order for Flonase 50mcg, one spray into each nostril twice daily at 7:00am and 8:00pm. Interview on 8/8/23 with the facility's nurse revealed the MTs should be looking at the Medication Administration Record (MAR) when administering medications and the Flonase should not have been administered twice within that time frame. The nurse stated, "That's a really big error."	W 369		
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 observations, record review and interviews, the facility failed to ensure client #9 was taught to use her eyeglasses appropriately and to make informed choices about their use.	W 436		

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W 436	Continued From page 10 This affected 1 of 7 audit clients. The finding is: During morning observations in Wakulla I on 8/8/23, the 1st shift Medication Technician (MT) gave client #9 a pair of eyeglasses located on a desk in the office of the home. The client put the eyeglasses on and left the area. Immediate interview with the MT revealed client #9's eyeglasses are kept in the office because she breaks them. Review on 8/8/23 of client #9's Individual Program Plan (IPP) dated 3/7/23 revealed the client wears eyeglasses as needed. Additional review of the plan did not include any training to teach the client to use her eyeglasses appropriately or to assist her with making informed choices about her eyeglasses. Interview on 8/8/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #9 had worked on an objective to wear her eyeglasses; however, it had been completed. The QIDP acknowledged more training may be needed.	W 436		
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 client #3's modified and specially-prescribed diet was	W 460		

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W 460	Continued From page 11 provided as indicated. This affected 1 of 7 audit clients. The finding is: During observations of breakfast preparation in Wakulla I on 8/8/23 at 7:14am, Staff C placed client #3's sausage patties in a food processor, added water and ground it up. Once finished, the sausage was finely ground with visible liquid and pieces of meat throughout. Client #3 consumed the sausage without difficulty. Immediate interview with Staff C revealed client #3 consumes a pureed diet and this is how they routinely process her food. Review on 8/8/23 of client #3's physician's orders dated 6/8/23 revealed an order for a pureed diet. Additional review of the menu located in the kitchen of the home indicated pureed food should be "blended smooth". Interview on 8/8/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3 consumes a pureed diet which should look like applesauce or pudding. The QIDP also indicated staff have been trained to add milk and bread to certain foods like sausage which may be more difficult to puree.	W 460		