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 _____	07/16/2025

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 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 that a continuous active treatment programs consisting of needed behavioral interventions and adaptive equipment that were implemented as identified in the person-centered plan (PCP) for 4 of 4 sampled clients (#1, #2, #4, #5). The findings are: A. The facility failed to follow behavioral interventions for client #4 relative to target behaviors. For example: Observations throughout the recertification survey from 7/15/25-7/16/25 revealed client #4 to pace throughout the facility while sporadically kicking the wall. Further observations reveal client #4 to make growling noises and make attempts to bite at surveyors and staff. Observations did not reveal staff to address or redirect client #4 from kicking and biting. Review of the record for client #4 on 7/16/25 revealed a PCP dated 6/10/25 which indicated the client has the following diagnoses: Tourette's Syndrome, I/DD moderate, unspecified Psychotic	W 249		

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

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W 249	Continued From page 1 Disorder, Obsessive Compulsive Disorder (OCD), neurogenic bladder, GERD, Helicobacter Pylori infection, Vitamin D3 deficiency, Hyperopia, Astigmatism, seasonal allergies, and history of Seizure Disorder. Subsequent review of the record for client #4 revealed a behavioral support plan (BSP) dated 2/10/25 which indicated the client has the following target behaviors: resistance/refusal, physical and verbal aggression, property destruction, skin picking, psychotic behavior, bossing others, and other obsessive-compulsive acts. Further review of the record for client #4 revealed the following interventions for physical aggression: "if she starts kicking/hitting the wall, direct her to her room, then offer her a foam bat to use instead of her feet, arm, or hand. Support her in releasing the aggression.Wait until she is calm for at least 5 minutes prior to encouraging her to return to her regularly scheduled activity". Continued review of the 2/2025 BSP revealed if the client "gets excited and bites someone during a greeting, tell her to STOP and block her action with your body or hand. Then demonstrate and verbally instruct her the proper way to greet someone by shaking their hand. Give her an opportunity to shake the person's hands and your hand using correct social techniques. Praise her for appropriate social behavior". Interview with the behavioral specialist on 7/16/25 revealed client #4 often exhibits these behaviors and they are how the client communicates affection. Further interview with the behavioral specialist revealed staff should utilize the interventions if the client's behaviors become extreme.	W 249		

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W 249	Continued From page 2 Interview with the qualified intellectual disabilities professional (QIDP) on 7/16/25 verified that all of the behavioral interventions for client #4 are current. Further interview with the QIDP verified staff have been trained to utilize the BSP for client #4's target behaviors as prescribed. B. The facility failed to follow mealtime guidelines as prescribed for client #5. For example: Morning observations on 7/16/25 at 8:05AM reveled client #5 to sit at the dining table participating in the breakfast meal. Further observations revealed client #5 to eat at a fast pace with excessive spillage on the table and floor. Continued observations revealed client #5 to overstuff her mouth several times during the breakfast meal while talking to staff. Observations did not reveal staff to redirect client #5 or prompt the client to slow her rate of eating as prescribed. Review of the record for client #5 on 7/16/25 revealed a PCP dated 1/7/25 and occupational therapy (OT) Assessment dated 11/25/24. Further review of the 7/2025 PCP revealed client #5 has mealtime guidelines that must be followed to slow her rate of eating. Continued review of the 7/2025 PCP revealed the following interventions relative to mealtimes: "after two verbal prompts and/or partial physical prompts to slow rate of eating, staff should move her plate to the center of the table to give the client a chance to chew and swallow her current bite. Then the plate can be reintroduced, and she would again be prompted two times before the plate would be removed and prompt sequence will be repeated until her meal is finished". Interview with the QIDP on 7/16/25 verified the	W 249		

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W 249	Continued From page 3 mealtime guidelines for client #5 are current. Further interview with the QIDP revealed staff have received training on mealtime guidelines for client #5. Continued interview with the QIDP verified staff should follow client #5's mealtime guidelines as prescribed. C. The facility failed to provide and utilized client #1's gait belt as prescribed. Observation at the home on 7/15/25 from 4:40 PM-5:10 PM revealed client #1 was observed not wearing her gait belt. Further observation revealed client #1 to participate in preparing the dinner meal and her gait was unsteady (X2) while attempting to retrieve items from the kitchen pantry. Observation at the home on 7/16/25 from 7:10 AM-8:20 AM revealed client #1 was observed not wearing her gait belt. Further observation revealed client #1 to participate in the breakfast meal and she cleaned the dining room table afterwards; her gait was unsteady (X3). Review of the record on 7/15/25 for client #1 revealed a PCP dated 8/1/24 which identified the following adaptive equipment: walker, wheeled walker, gait belt, buckle buddy, helmet, eyeglasses. Further review of the PCP indicated client #1's gait belt and walker to be always utilized per PT evaluation (if client #1 does not want to use her walker, staff need to ensure that they are supporting her in mobility by holding on to her gait belt while she is up and mobile). Interview on 7/16/25 with the QIDP confirmed client #1 should have been wearing her gait belt she is up and mobile.	W 249		

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W 249	Continued From page 4 D. The facility failed to follow behavioral interventions for client #2 relative to target behaviors. For example: Observations throughout the recertification survey from 7/15/25-7/16/25 revealed client #2 to follow surveyor throughout the facility while interlocking her arm with surveyors' arm and attempting to kiss surveyor (X3) in the face. Further observations did not reveal staff to address or redirect client #2 attempts at kissing and holding on to the surveyor. Review of the record on 7/15/25 for client #2 revealed a behavioral support plan (BSP) dated 3/3/25 which indicated client #2 has the following target behaviors: Cooperation, property destruction, tantrums, inappropriate social behavior (inappropriate acts that violate the personal space of others such as trying to kiss others, playing with and/or smelling hair of others, or trying to hug others), taking others belongings, and elopement. Further review of the record for client #2 revealed the following interventions for inappropriate social behavior: "if client #2 is observed engaging in inappropriate or unsafe behavior, staff should immediately redirect her to a scheduled task, offering support and hand over hand prompts as needed". Interview with the qualified intellectual disabilities professional (QIDP) on 7/16/25 verified that all of the prevention guidelines for interaction for client #2 are current. Further interview with the QIDP verified staff have been trained to utilize the BSP for client #2's target behaviors as prescribed. Continued interview with the QIDP verified staff should follow client #2's prevention guidelines as	W 249		

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W 249	Continued From page 5 written.	W 249		
W 488	DINING AREAS AND SERVICE CFR(s): 483.480(d)(4) The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observations and interviews, staff failed to provide appropriate dining utensils to 2 of 4 sampled clients (#1, #3) to enable them to eat at their developmental level. The findings are: A. The facility failed to provide appropriate dining utensils to client #3 relative to a dycem mat. For example: Observations on 7/16/25 at 8:05AM revealed client #3 to sit at the dining room table to prepare for the breakfast meal. Further observation revealed staff to place client #3's plate and dycem mat on top of a piece of paper towel. Continued observation revealed client #3 to consume the breakfast meal as staff would occasionally re-adjust the client's plate on top of the paper towel. Interview with staff E on 6/25/25 revealed staff place the clients' plates on top of the shirt protector to minimize spillage during mealtimes. Interview with the qualified intellectual disabilities professional (QIDP) on 7/16/25 revealed staff should not have placed the clients' plates on top of a piece of paper towel during mealtimes. Further interview with the QIDP revealed staff have been trained to provide dignity and respect to clients and use the clients' prescribed adaptive equipment during mealtimes.	W 488		

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W 488	Continued From page 6 B. The facility failed to instruct client #5 to use her adaptive equipment during mealtimes. For example: Observations on 7/16/25 at 8:05AM revealed client #5 to enter the kitchen to prepare her plate for the breakfast meal. Observations revealed staff to place a table setting to include a maroon spoon and regular spoon for client #5. Further observation revealed client #5 to sit at the dining table and participate in the breakfast meal without using her maroon spoon. At no point during the observation did staff prompt client #5 to use her maroon spoon during the breakfast meal. Review of the record for client #5 on 7/16/25 revealed a PCP dated 1/7/25 and OT assessment dated 11/25/24 which indicated the client uses a maroon spoon during mealtimes due to rate of eating, scooping too large bites and overstuffing her mouth when eating. Interview with the QIDP on 7/16/25 revealed staff should have prompted client #5 to use her maroon spoon during mealtimes in order to slow her rate of eating and prevent the client from overstuffing her mouth. Further interview with the QIDP verified client #5's adaptive equipment and interventions were current. Continued interview with the QIDP verified staff have been trained to provide and instruct clients to use their adaptive equipment during mealtimes as prescribed.	W 488		