DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/07/2018 FORM APPROVED OMB NO. 0938-0391

| NAME OF PROVIDER OR SUPPLIER LIFE, INC FOLLY STREET GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 65 FOLLY STREET SW SUPPLY, NC 28462 (X4) ID PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 65 FOLLY STREET SW SUPPLY, NC 28462 (X4) ID PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CMPLE DATE | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) I | DATE SURVEY COMPLETED | |
|--|---|--|---|--|--|---|--------------------------|--|
| NAME OF PROVIDER OR SUPPLIER LIFE, INC FOLLY STREET GROUP HOME STREET ADDRESS, CITY, STATE, ZIP CODE 65 FOLLY STREET SW SUPPLY, NC 28462 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE' TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE | | | 34G235 | B. WING | | | | |
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| | PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SECTION SECTIO | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | |
| W 000 INITIAL COMMENTS A complaint investigation was conducted on 11/2/18 after it was reported that the clients were left unsupervised in the home. There were no deficient practices cited and the facility was in compliance to regulations related to the allegation. W 000 W 000 | W 000 | A complaint investiga 11/2/18 after it was re left unsupervised in the deficient practices cite compliance to regulate | ation was conducted on eported that the clients were no home. There were no hed and the facility was in | WO | | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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.