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	34G034	A. BUILDING _____ B. WING _____	12/18/2018

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LIFE, INC. WALNUT STREET GROUP HOME	1011 EAST WALNUT STREET GOLDSBORO, NC 27530

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 5 audit clients (#2, #6) had the right to be treated with dignity regarding the use of a washable incontinence pad placed underneath them as they sat. The findings are: Clients #2 and #6 dignity was not considered regarding the use of a washable incontinence pad placed underneath them as they sat. a. During morning observations in the home on 12/17/18 from 11:46am until 1:15pm, client #2 was seated in her wheelchair with a washable incontinence pad underneath her; it was visible to anyone in the home. During afternoon observations in the home on 12/17/18 at 4pm, client #2 was seated in her wheelchair with a washable incontinence pad underneath her; it was visible to anyone in the home. During an interview on 12/17/18, staff revealed client #2 sits on the incontinence pads "just incase she wets." Further interview revealed client #2 will tell staff when she needs to use the restroom of when she is wet. Review on 12/18/18 of client #2's individual	W 125		

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

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program plan (IPP) dated 12/13/18 stated, "I wear pull-ups due to incidents of leaking urine, urinating and defecating. Staff continue to assist me with getting on and off the toilet...."

Review on 12/18/18 of client #2's adaptive behavior inventory (ABI) dated 9/11/18 revealed client #2 is totally dependent on staff for toileting.

During an interview on 12/18/18, the qualified intellectual disabilities professional (QIDP) revealed staff "try to take her" to the restroom 1 - 2 hours. Further interview revealed how the QIDP was unaware how having client #2 sitting on a incontinence pad was not dignified.

b. During morning observations in the home on 12/18/18 from 6:35am until 6:52am, client #6 was observed to be sitting in a chair in the living room. Further observations revealed client #6 was sitting underneath an washable incontinence pad.

During an interview on 12/18/18, the staff stated third shift put it in the chair for client #6 to sit on. Further interview revealed client #6 can verbally tell staff when she needs to use the restroom.

Review on 12/18/18 of client #6's IPP dated 9/7/18 stated, "Staff are to encourage me to go to the restroom frequently to prevent me from urinating on myself...I wear adult diapers daily due to my frequency of urination.

Review on 12/18/18 of client #6's ABI dated 5/9/18 revealed client #6 is able to signal to staff when she needs to go to the restroom.

During an interview on 12/17/18, the QIDP was unaware how having client #6 sitting on a

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W 125	Continued From page 2 incontinence pad was not dignified.	W 125		
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 observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of supervision and behavior management. This affected 2 of 5 audit clients (#2, #5). The findings are: 1. Client #2's supervision guidelines where not followed. During afternoon observations in the home on 12/18/18 from 11:50am until 11:53am, client #2 was left sitting alone in the living room while the one staff assigned working in the home, walked down the hallway to assist another client in the restroom and then into the kitchen. Further observations revealed client #2 was visible to the staff. During an interview on 12/18/18, the staff stated,	W 249		

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"normally there would be 2 staff this morning, but not this morning." Further interview revealed she was the assigned one on one staff for client #2.

During an interview on 12/18/18, a second shift staff revealed client #2 will try to get up out of her wheelchair, even though the wheelchair has a seatbelt. Further interview revealed client #2 is a falls risk.

Review on 12/17/18 of client #2's IPP dated 12/13/18 stated, "I continue to have an assigned one-on-one staff to work with me on first and second shift every day of the week die to my decline in health and daily abilities." Further review revealed, "I require constant supervision from staff to ensure my personal safety."

During an interview on 12/17/18, the facility's nurse revealed the supervision guideline for client #2 was put into place about five years ago when she was going though chemotherapy, when she would try and get out of her chair. Further interview revealed the supervision level for client #2 has changed since she no longer attempts to stand up.

During an interview on 12/17/18, the qualified intellectual disabilities professional (QIDP) revealed the supervision guidelines for client #2 should have been removed from her IPP.

2. Client #5's behavior intervention plan was not followed.

During morning observations in the home on 12/18/18 at 9am, client #5 was observed to stand up from the table and began pointing towards where the sink was located. Staff began to

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verbally prompt her how she needed to leave the kitchen and go into the restroom to brush her teeth. Another staff then asked her if she wanted to wash her dishes from breakfast. Further observations revealed client #5 walking towards the sink. Client #5 then turned her back towards the sink and stood still. Staff began using her gait belt to physically walk her out of the kitchen. Additional observations revealed two staff again began asking client #5 again did she want to do dishes and how she needed to go brush her teeth, so that she could get ready to go to the day program.

During an interview on 12/18/18, staff revealed client #5 does have a behavior plan. Further interview revealed she verbally prompted client #5 "about every three minutes." The staff reported how maybe having two different staff verbally prompting client #5, might have confused her. Additional interview revealed the staff revealed, "I followed her plan, as best as I could."

Review on 12/18/18 of client #5's behavior intervention plan (BIP) dated 11/15/18 revealed, "...III. Target Behavior Definitions: A. Avoidance - Anytime [Client #5] is observed exhibiting behavior of avoiding...scheduled activity after two redirections...."V. Consequences for Target Behavior Occurrences: A...Avoidance: 1. Staff should periodically every 5 to 8 minutes approach her...direct her to a task...should make the request with limited verbal interaction or eye contact...."

During an interview on 12/18/18, the QIDP revealed client #5's BIP should have been followed as written.

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W 368	Continued From page 5	W 368		
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 review and interviews, the facility failed to ensure the system of administrating medications as ordered was implemented. This affected 1 of 5 audit clients (#6) The finding is: Client #6 did not receive her Polyeth Glyc Powder as ordered. During medication administration observation in the home on 12/18/18, the medication technician combined client #6's Polyeth Glyc Powder with Lactulose, eleven pills and pudding. Further observations revealed client #6 feeding herself the mixture with a spoon. Review on 12/18/18 of client #6's physician orders revealed, "Polyeth Glyc Pow: Measure and mix 17 grams in 8 oz of water and give by mouth...." During an interview on 12/18/18, the medication technician revealed the facility nurse told her client #6's Polyeth Glyc Powder could be mixed with all her other medications into either applesauce or pudding without using the 8 ounces of water. During an interview on 12/18/18, the facility nurse confirmed there was not an physicians order	W 368		

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W 368	Continued From page 6 indicating client #6's Polyeth Glyc Powder could be mixed into pudding or applesauce.	W 368		
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 recommended equipment specifically eyeglasses were furnished for 1 of 5 audit clients (#1). The finding is: Client #1 was not prompted to wear her eyeglasses. During observations at the day program on 12/17/18, from 10:30am until 11:40am, client #1 was not prompted to wear her eyeglasses. During morning observations in the home on 12/18/18, client #1 was not prompted to wear her eyeglasses prior to getting on the van to attend the day program. Review on 12/17/18 of client #1's individual program plan (IPP) dated 5/24/18 stated, "Adaptive Equipment: I wear glasses and choose to wear then at the workshop, although this is done inconsistently. I put them on before going	W 436		

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W 436	Continued From page 7 to the workshop and remove them after returning home. My glasses are kept in the office closet with open availability to me." During an interview on 12/18/18, the qualified intellectual disabilities professional (QIDP) was unaware client #1 wore eyeglasses.	W 436		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infection and prevent possible cross-contamination. This potentially affected 6 clients residing in the home. The finding is: Precautions were not taken to promote client health and prevent possible cross-contamination. During breakfast observations in the home on 12/18/18, a client used her personal spoon, which had previously been used, to obtain artificial sweetener for her coffee. Client #4 then passed the artificial sweetener to client #1 who proceeded to use her personal spoon, which had previously been used, to obtain artificial sweetener for her coffee. During an interview on 12/18/18, the habilitation coordinator revealed she had observed client #1 using her personal spoon to obtain the artificial	W 455		

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W 455	Continued From page 8 sweetener, but not client #4.	W 455		
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 a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the area of diet. This affected 1 of 5 audit clients (#6). The finding is: 1. Client #6's diet consistency were not followed. During dinner observations in the home on 12/17/18, client #6's coffee was prepared by staff. Further observations revealed staff had put 1 packet of Thick It into the coffee and had client #6 stir the coffee; staff then put a straw into the coffee cup. Additional observations revealed the coffee was regular consistency. Client #6 used the straw to drink the coffee and proceeded to cough. At no time was the coffee rechecked to ensure it was the correct consistency. During an interview on 12/17/18, staff revealed client #6's liquids "have to be honey thick, because she can't swallow thin liquids." Review on 12/17/18 of the facility's diet orders dated 12/17/18 indicated client #6 liquids are honey thick.	W 460		

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W 460	Continued From page 9 Review on 12/18/18 of client #6's nursing evaluation dated 8/3/18 stated, "Honey thick liquids...." Review on 12/18/18 of client #6's nutritional evaluation dated 8/27/18 revealed, "...honey - thick liquids....She has a hx of dysphagia and receives honey think liquids." During an interview on 12/18/18, the habilitation coordinator reported, "Seems coffee does not get honey thick when Thick It is added to it."	W 460		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food substitutions were documented. The finding is: Food substitutions were not documented. During lunch observations in the home on 12/17/18, staff substituted potato chips and gold fish crackers for pretzels and pudding and applesauce of fig newtons. Staff was not observed documenting the food substitution. During an interview on 12/18/18, staff revealed whenever a food item is substituted the food substitution form should be filled out. During an interview on 12/13/18, the habilitation coordinator confirmed all meal substitutions should be documented.	W 481		

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