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

PRINTED: 01/31/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G288	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED 01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	1320 GREEN TEE LANE ROCKY MOUNT, NC 27804

(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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	E 039	E039 The facility will ensure that they participate, at least annually, in either a facility or community-based tabletop exercise to test the emergency plan. The QP will be responsible for ongoing compliance with this regulation and will document the tabletop exercise and file with the emergency plan. DHSR - Mental Health FEB 13 2019 Lic. & Cert. Section	3-29-2019

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara W. Parker	Dir of ICF IID	2-12-19

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G288	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	1320 GREEN TEE LANE ROCKY MOUNT, NC 27804

(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
E 039	Continued From page 1 *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is: The facility's Emergency Preparedness (EP) plan did not include completion of facility/community-based exercise or tabletop exercise. Review on 1/28/19 of the facility's EP plan (updated 11/14/18) did not include a full-scale community-based or individual facility-based exercise or a tabletop exercise to test their emergency plan. Interview on 1/29/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the facility has not conducted a full-scale facility/community-based exercise or a tabletop	E 039		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G288	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	**1320 GREEN TEE LANE ROCKY MOUNT, NC 27804**

(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
E 039	Continued From page 2 exercise to test the effectiveness of their current emergency plan.	E 039		
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 review and interviews, the facility failed to ensure client #3's Individual Program Plan (IPP) included specific information to support the use of her eye glasses. This affected 1 of 3 audit clients. The finding is: Client #3's IPP did not include information regarding the use of her eye glasses. During evening observations in the home on 1/28/19 from 3:35pm - 6:15pm, client #3 did not wear eye glasses. During this time, the client participated in tasks such as working in an activity book for crossword puzzles. Client #3 was not prompted to wear eye glasses. Review on 1/29/19 of client #3's IPP dated 7/13/18 revealed, "...visual examination was completed on 1-22-18. Functional vision. No diabetic Retinopathy. New glasses prescription given for Myopia." Additional review of the client's vision examination report dated 1/22/18 noted, "Glasses prescribed to help improve patient visual acuity." Further review of the IPP did not provide specific information regarding the use of client #3 eye glasses.	W 240	W240 The facility will ensure that all clients prescribed eyeglasses or other devices receive education and training in the use of wearing them. Each individual will be re-evaluated on the use of eyeglasses and training goals will be implemented as warranted. All staff will receive additional training to address each individual's needs. The QP and Habilitation Coordinator will monitor on an ongoing basis utilizing monthly inspection forms that will consist of no less than 3 per month.	3-29-2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G288	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	1320 GREEN TEE LANE ROCKY MOUNT, NC 27804

(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 240	Continued From page 3 Interview on 1/29/19 with the Qualified Intellectual Disabilities Professional (QIDP) stated, "I don't know if it specifies" when asked if client #3's IPP includes any specific information regarding when she should be wearing her eye glasses.	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 3 of 3 audit clients (#2, #3, #5) received a continuous active treatment plan consisting of needed interventions as identified in the Individual Program Plan (IPP) in the areas of food consistency/diets, self-help skills, and splint use. The findings are: 1. Clients' diets were not followed at dinner. During observations of dinner preparation in the home on 1/28/19 at 4:49pm, staff added salt to macaroni and carrots while preparing them on the stove. At 5:52pm, staff prompted a client to add salt to a pot green beans which were specifically prepared for client #2. Later, at the dinner meal, client #2 and client #3 consumed food items with added salt.	W 249	W249 The facility will ensure that each consumer receives continuous active treatment to support their Individual Program Plan. All staff will be re-trained on each individuals IPP to include, but not limited to diet order, diet consistency, the use of adaptive equipment and self-help skills. The QP and Habilitation Coordinator will monitor utilizing monthly inspection forms that will consist of no less than 3 per month.	3-29-2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G288	A. BUILDING ____ B. WING ____	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	1320 GREEN TEE LANE ROCKY MOUNT, NC 27804

(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	Continued From page 4 Staff interview on 1/29/19 revealed seasoning salt and other seasonings are routinely added to food items prepared in the home. Review on 1/28/19 of client #2's IPP dated 9/20/18 revealed a physician's order dated 12/20/18. The order noted, "...soft diet NAS..." Review on 1/28/19 of client #3's IPP dated 7/13/18 indicated she receives a regular diet "with NAS". Interview on 1/29/19 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed NAS stands for "No Added Salt". Additional interview confirmed salt should not be added to foods while cooking. 2. Client #2's food consistency was not followed at breakfast. During breakfast observations in the home on 1/29/18 at 6:49am, client #2 was assisted to serve herself scrambled eggs and two small sausage biscuits. The client consumed the biscuits uncut and the biscuits were not moistened. Staff interview on 1/29/19 revealed client #2's food should be in small pieces and soft. Review on 1/28/19 of client #2's current physician's orders dated 12/20/18 revealed, "...All foods finely chopped into 1/4" pieces - may moisten foods if needed..." Interview on 1/29/19 with the QIDP confirmed client #2's food should be the size of a pea and	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G288	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	1320 GREEN TEE LANE ROCKY MOUNT, NC 27804

(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	Continued From page 5 moistened if needed. Additional interview with the Habilitation Coordinator indicated staff should use a chopper for client #2's food to ensure it is cut small enough. 3. Client #3's diet was not followed at lunch. During lunch observations at the day program on 1/28/19 at 12:32pm, client #3 consumed hamburger helper, a sandwich size zip lock bag of regular potato chips, a bag of Doritos, and a salad with dressing. Staff interview on 1/28/19 revealed client #3 does not like sandwiches and chose to have the hamburger helper instead. Additional interview indicated she should not have two bags of potato chips. Further interview on 1/29/19 noted client #3's snack choices should be fruit or baked potato chips. Review on 1/28/19 of client #3's IPP dated 7/13/18 revealed she should consume a regular diet with "no added salt, sugar free/no sugar added condiments...second single servings of any fruit or non-starchy vegetables if hungry after meals...low calorie or zero calorie snacks..." Interview on 1/29/19 with the QIDP revealed client #3 will often sneak more food into her lunch bag and needs to be monitored for food stealing which is included in her behavior plan. 4. Client #2's hand splint was not applied as indicated. During evening observations in the home on 1/28/19 from 3:35pm - 6:15pm, client #2 did not wear a splint on her right hand. The client was	W 249		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G288	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	1320 GREEN TEE LANE ROCKY MOUNT, NC 27804

(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	Continued From page 6 not prompted or assisted to wear a hand splint. Staff interview on 1/29/19 revealed client #2 does have a hand splint she wears; however, she does not like to wear it. Review on 1/29/19 of client #2's IPP dated 9/20/18 revealed, "I will continue with the use of all adaptive equipment." The plan also noted the client should wear a right cock-up splint 5 days per week. Further review of the client's training book indicated guidelines for use of the hand splint which indicated it should be worn three times per day from 10a - 12p, 1p - 3p and 5p - 7p. The guidelines noted, "This is very important. Do Not Forget!!" Interview on 1/29/19 with the QIDP confirmed client #2's hand splint should continue to be applied as indicated. 5. Client #5 was not prompted to participate with the administration of her medications to her maximum potential. During observations of medication administration at the day program on 1/28/19 at 11:32am, client #5 obtained a cup of water, repeated why she receives her medication, ingested her medication and left the medication area. During this time, the medication technician retrieved the pill card, told the client the name of her pill, punched the pill, returned the pill card and threw away trash. Immediate interview with the staff involved revealed client #5 can "do a lot" duirng the medication pass. Review on 1/29/19 of client #5's IPP dated	W 249		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G288	A. BUILDING ______ B. WING ______	01/29/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	1320 GREEN TEE LANE ROCKY MOUNT, NC 27804

(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	Continued From page 7 7/12/18 revealed, "I can identify my own med basket, pour my own water, and assist staff with dispensing my med...I am able to throw my trash away and return my basket to the cabinet. Staff will continue to work with me informally on stating the purpose of my meds..." Interview on 1/29/19 with the QIDP confirmed staff should assist client #5 to participate with the administration of her medications as indicated in her plan.	W 249		
W 382	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) The facility must keep all drugs and biologicals locked except when being prepared for administration. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure client #2's medications were kept locked except when being administered. The finding is: Client #2's medications were not kept locked. During observations of medication administration in the home on 1/29/19 at 7:18am, staff dispensed Calcium, Depakote, Keppra and Vimpat for client #2's morning medications. Client #2 refused the medications which were placed in a small cup and mixed in applesauce. The medication technician attempted to offer the medications to client again but she continued to refuse them. The pill mixture (now with Sherbert added) was covered with foil and placed in the refrigerator. While in the refrigerator from	W 382	W382 The facility will ensure that all medications remain locked except for instances when staff are administering medications. Staff will be in-serviced to ensure that medications are kept locked when not being administered. This plan of correction will be monitored by the QP, Habilitation Coordinator, and nurse on an going basis through scheduled inspections a minimum of three times per month.	3-29-2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G288	A. BUILDING ______ B. WING ______	**01/29/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREEN TEE LANE	**1320 GREEN TEE LANE ROCKY MOUNT, NC 27804**

(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 382	Continued From page 8 approximately 8:12am - 9:30am, client #2's medications were not kept locked. During this time, another client was observed going into the refrigerator unsupervised. Interview on 1/29/19 with the facility's nurse via telephone revealed the medication technician should have placed the pills in the refrigerator of the medication room and this area should have been locked while waiting for client #2 to consume her medication.	W 382		