STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G091	A. BUILDING _____ B. WING _____	10/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC LAVENHAM GROUP HOME	3700 LAVENHAM ROAD NEW BERN, NC 28560

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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 #1's Individual Program Plan (IPP) included specific information to support his use of a gait belt. This affected 1 of 3 audit clients. The finding is: Client #1's IPP did not include specific information regarding the appropriate use of his gait belt. During observations throughout the survey at the day program and in the home on 10/1 - 10/2/19, client #1 wore a gait belt secured around his waist. At times, the client walked unassisted by staff. Additional observations revealed staff holding the client by his arm or wrist. Further observations revealed staff holding on to the gait belt as client #1 walked down steps or outside. On at least two occasions, Staff B held the client's gait belt to prevent him from leaving an area. Interview on 10/2/19 with Staff B revealed client #1's gait belt is used to prevent falls when he is walking. Additional interview indicated the client wears the belt because he "sometimes sees steps that aren't there." The staff noted they do not have to hold onto the client's gait belt all the time. Review on 10/1/19 of client #1's IPP dated 9/13/19 revealed his "Gait belt is utilized as a guide to help prevent falls." The plan did not	W 240		

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

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W 240	Continued From page 1 include any other information regarding use of his gait belt. Interview on 10/2/19 with the Qualified Intellectual Disabilities Professional II (QIDP) and another management staff revealed client #1's gait belt should be used by staff to assist him to stand if he drops to the floor unexpectedly. The QIDP indicated his intentional falls to the floor may be related to his increased dementia symptoms. Additional interview indicated the gait belt is also used to prevent him from falling during ambulation on uneven surfaces. The interview did not indicate the gait belt should be used to direct the client's movements. Further interview confirmed specific information regarding the gait belt's use is not included in his IPP.	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 2 of 3 audit clients (#1, #4) received a continuous active treatment plan consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of	W 249		

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W 249	Continued From page 2	W 249		

self-help/domestic skills and adaptive equipment use. The findings are:

1. Client #1 was not prompted or encouraged to assist with self-help/domestic tasks.

a. During lunch observations at the day program on 10/1/19 at 11:47am, during medication administration in the home on 10/2/19 at 7:11am and during breakfast observations in the home on 10/2/19 at 8:13am, client #1's drinks were poured for him. Although the client was present, he was not prompted to participate with this task.

Interview on 10/2/19 with Staff B revealed client #1 can't pour on his own due to vision problems and "can't see his cups" so his hands would need to be "guided" for pouring.

b. During observations in the home on 10/2/19 at 8:13am, client #1 was assisted to obtain the necessary items to set his place at the table. The client was assisted to carry the items to the table. Once at the table, Staff A set up the items at his place setting for him as he stood nearby unengaged.

Interview on 10/2/19 with Staff B indicated client #1 can set his place setting with assistance.

c. During observations in the home on 10/2/19 at 8:42am, Staff B cleared client #1's dirty dishes for him without prompting him to participate with this task.

Interview on 10/2/19 with Staff B revealed client #1 can "somewhat" clear his place; however, he sometimes "loses his balance".

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W 249	Continued From page 3 Review on 10/2/19 of client #1's Adaptive Behavior Inventory (ABI) dated 10/16/18 revealed he can independently set the table with dishes already selected and clear the table after meals. Additional review of the client's IPP dated 9/13/19 revealed he can pour his beverages independently. Interview on 10/2/19 with the Qualified Intellectual Disabilities Professional II (QIDP) and another management staff indicated client #1 requires physical assistance to complete tasks such as setting his place at the table, clearing his place and pouring beverages. 2. Client #4 was not wearing glasses during activities. During observations on 10/1/19 and 10/2/19 at the day program and in the home, client #4 was observed to be participating in activities such as flash cards (at the day program), several puzzles of various sizes, and a etch-a-sketch game. At no time during the observations was client #4 observed to be wearing glasses. Review on 10/1/19 of client #4's IPP dated 9/13/19 revealed that client #4 has adaptive equipment of OTC 2.5 reading glasses. Further review of the IPP revealed that "prescription eyeglasses are not required at present but is optional for group home activities, may use OTC 2.5 readers if he needs to focus." Review on 10/2/19 of client #4's record revealed a vision exam dated 10/4/18. The exam revealed a spectacle plan "Bilateral: Rx optional for home activities, OTC readers 2.50."	W 249		

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W 249	Continued From page 4 Interview on 10/2/19 with the QIDP II and another management staff revealed that client #4 does have OTC readers. When asked what type of activities would require client #4 to wear his glasses, the QIDP II stated activities such as looking at magazines, when out in the community such as the library, or when he has to focus on something. When further asked if this would mean looking at items such as flash cards, the QIDP II confirmed client #4 would have needed his glasses for those types of activities.	W 249		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that positive interactions were provided for 1 of 3 audit clients (#1). The finding is: Staff failed to provide a pattern of positive interactions. During observations in the day program on 10/1/19 at 10:52am, client #1 was standing in the threshold of the doorway of one of the activity rooms. He was waiting to get to his seat due to the congestion of several of his peers trying to get in and out of the room. A staff pushing a client in a wheelchair came up behind client #1 and was trying to get into the room. The staff took his hand and pushed client #1 on his lower back and	W 268		

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W 268	Continued From page 5 said "move." When client #1 did not move, the staff pushed client #1 on his lower back again and said "move out the way." Interview on 10/2/19 with the qualified intellectual disabilities professional II (QIDP) and another management staff revealed that the expectation is that staff are to wait until there is room for client #1 to sit and then push the client in the wheelchair into the room. In addition, the QIDP II and other management staff revealed it is never acceptable for a staff to take their hand and push an individual in their back and tell them to "move out the way."	W 268		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure only authorized persons had access to the keys to the medication closet. The finding is: The keys to the medication closet were accessible to unauthorized persons. During morning observations in the home on 10/2/19 at 8:17am, the keys to the medication closet were inside an unattended bag inside the dining room. At 9:01am and 9:09am, the keys were observed on the dining room table. A client was also observed to pick up the keys briefly at 9:12am. Additional observations at 9:17am revealed the medication technician (MT) returned	W 383		

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W 383	Continued From page 6 the keys to the unattended bag in the dining room where they remained until 9:25am when the MT retrieved the bag and prepared to leave the home. Interview on 10/2/19 with the MT revealed the keys to the medication closet should be kept by the MT. Additional interview indicated there used to be a separate lanyard for the med keys which allowed the MT to carry the keys around their neck. The MT also indicated they did not have any pockets on their clothing in which to place the keys. Review on 10/2/19 of the facility's Annual Medication Review form (last revised 5/2014) revealed the medication keys should be kept "on the staff giving meds". Interview on 10/2/19 with the Qualified Intellectual Disabilities Professional II (QIDP) and other management staff confirmed the medication technician should retain the keys to the medication closet when assigned to give meds on a shift.	W 383		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected all clients residing in the home. The finding is:	W 454		

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W 454	Continued From page 7 Precautions were not taken to prevent possible cross-contamination during meal preparation tasks. During afternoon observations in the home on 10/1/19 from 4:25pm until 5:24pm, client #4 and Staff D were in the kitchen preparing the evening meal. At 4:25pm, Staff D and client #4 washed their hands. They began chopping up a head of cabbage, cutting off the end pieces. Staff D gave client #4 the end and outer pieces of the cabbage to throw in the trash can. Client #4 was observed to throw the cabbage in the trash can, pull them back out, push them back in, pull them back out, push them back in, pull them back out and push them back in to the trash can. Client #4 then opened the drawer and began touching the spoons that were laying in the drawer organizer that would be used to eat with at dinner. Client #4 and Staff D were then observed opening a can of baked beans, pouring them into a pot, and client #4 began stirring the beans. Client #4 and Staff D walked outside to the freezer, obtained a package of dinner rolls, and came back inside. Client #4 and Staff D opened the package of rolls and used their bare hands to break apart the rolls and placed them in a dish to put in the oven. Client #4 and Staff D were observed to get bowls out of the cabinet and Staff D was observed to use her fingers to push her glasses up on her face. Client #4 was observed to bend down, push his sock down on his left leg and scratch his ankle. Client #4 and Staff D were then observed to take the pots of corn and baked beans and pour them into bowls, then take the BBQ chicken out of the oven and put on a serving platter. While Staff D was observed taking the cabbage out of the pot and putting them into a bowl, client	W 454		

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W 454	Continued From page 8 #4 was observed to use his bare hands to pick the dinner rolls up out of the dish they were warmed in and put them on a serving platter. Client #4 was not prompted to wash his hands again until 5:24pm when it was time to get ready to eat. Review of the facilities dietary department guidelines on 10/2/19 revealed for handwashing and food preparation that "handwashing should occur between handling cooked and uncooked foods" and "between handling of dirty dishes or equipment and handling clean utensils." In addition, "food is handled with utensils when possible and disposable gloves are used when necessary." Interview on 10/2/19 with the qualified intellectual disabilities professional II (QIDP II) and other management staff revealed the expectation is that when staff and clients are preparing meals, they are to wash their hands any time they touch different surfaces while cooking. In addition, staff are to prompt clients to wash their hands if the client is not independent in this skill. Further interview with the QIDP II revealed that staff are trained during their initial employment and annually on handwashing, cross contamination and bloodborne pathogens utilizing the dietary department guidelines.	W 454		
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.	W 460		

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W 460	Continued From page 9 This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure client #1's modified diet was provided as indicated. This affected 1 of 3 audit clients. The finding is: Client #1's food consistency was not provided as indicated. During dinner observations in the home on 10/1/19 at 5:30pm, client #1's baked chicken was cut up by staff. Once finished, the chicken was in various sizes and pieces at approximately 1/4" - 1/2". The client consumed the chicken without difficulty. Interview on 10/1/19 with Staff D revealed client #1's food consistency recently changed to a smaller size; however, they could not be sure exactly what that size was changed to. Interview on 10/2/19 with Staff B indicated client #1 used to have his food cut into 25 pieces but it was recently changed to a smaller size and his food needs to be placed in a chopper or a hand chopper should be used to make it the size of a grain of rice. Review on 10/1/19 of client #1's IPP dated 9/13/19 and his current physician's orders dated 9/30/19 revealed he should consume a regular "finely-chopped diet less than or equal to 1/4 (inch)" cut size. Interview on 10/2/19 with the Qualified Intellectual Disabilities Professional II (QIDP) and another management staff confirmed client #1's food consistency was recently down graded to "finely chopped or ground" to 1/4 inch or the size of a	W 460		

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W 460	Continued From page 10 grain of rice.	W 460		