STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G167	A. BUILDING _____ B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDLEWOOD GROUP HOME	103 WOOD GLENN ROAD ROANOKE RAPIDS, NC 27870

(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	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 reviews and interviews, the facility failed to assure relevant interventions or instructions to staff were addressed in the individual program plan (IPP.) This affected 1 of 3 audit clients (#5). The finding is: Client #5's IPP did not include interventions for staff to use in order to redirect a shirt lifting and belt unbuckling behavior. Throughout observations on 9/9-10/19, client #5 had episodes of lifting his shirt exposing his chest area as he unbuckles and buckle the belt. All the staff including the qualified intellectual disabilities professional (QIDP) constantly encouraged him to put his shirt down. At one time the QIDP offered to help the client use the bathroom. The client continued with the behavior immediately after leaving the bathroom. Review of client #5's record on 9/10/19 revealed an individual program plan (IPP) dated 5/1/19. The IPP did not indicate an active plan to address his shirt lifting and belt tightening behaviors. There was no information noted in the IPP as to how the staff should address the behaviors. An interview 9/9/19 with staff B revealed this is one of his ritual and he does that from time to time. Staff B and C revealed all staff try to redirect	W 240	W240 The facility will ensure that individual program plans for all clients describe relevant interventions to support the individuals toward independence, Specifically, the team will meet to discuss client #5's repetitive lifting of his shirt and buckling/unbuckling his belt. The results of the meeting for client #5, or any other client, will be shared with all staff working within the home so that any outlined written procedures for redirection will be implemented consistently. The QP and Habilitation Coordinator will monitor this plan of correction a minimum of 4 times monthly and will document findings on LIFE, Inc. QA/QI forms. DHSR-Mental Health OCT 08 2019 Lic. & Cert. Section	11-10-2019

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

Barbara W. Parker | Dir of ICF/IID | 10-3-19

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
	34G167	A. BUILDING _____ B. WING _____	09/10/2019

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IDLEWOOD GROUP HOME	103 WOOD GLENN ROAD ROANOKE RAPIDS, NC 27870

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W 240	Continued From page 1 him when he does that. Interview on 9/10/19 with the QIDP confirmed that he lifts up his shirt and keep unbuckling and buckling his belt and the behavior is not on a program to address it. The QIDP further confirmed client #5 program should address the behavior or inform staff of redirection needs.	W 240		
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #2 had a comfortable mattress. This affected 1 of 3 audit clients. The finding is: Client #2 was in need of a new mattress. During observations in the group home on 9/10/19, client #2's mattress was noted to have an indentation or dip in the middle. During an interview on 9/10/19, the facility's nurse acknowledged the mattress had a noticeably large dip or sink in the middle. During an interview on 9/10/19 with the qualified intellectual disabilities professional (QIDP) and program coordinator confirmed the mattress had a dip in the middle.	W 418	W418 The facility will provide each client with a clean comfortable mattress. The QP and the Habilitation Coordinator will inspect the mattress for all individuals in the home a minimum of 3 times monthly and document finings on LIFE, Inc. QA/QI forms. If a mattress needs to be replaced, the QP or Habilitation Coordinator will complete and submit a work order.	11-10-2019
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii)	W 473		

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	34G167	A. BUILDING _____ B. WING _____	09/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDLEWOOD GROUP HOME	103 WOOD GLENN ROAD ROANOKE RAPIDS, NC 27870

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W 473	Continued From page 2 Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure foods were served at an appropriate temperature. The finding is: Foods were not served at an appropriate temperature. During evening observations in the home on 9/9/19 at 5:57pm, Staff C turned the stove off. At 6:09pm the staff transferred the spaghetti and the meat sauce into serving bowls. The 2 bowls were placed on the dining table at 6:24pm and the staff checked the food temperature. At that time, client #2, #4, #5 were at the table. At 6:33pm clients #1, #3, #6 returned from the day's outing. They were prompted to the table and served the spaghetti and the sauce. The food was not reheated, and the temperature was not taken before serving. During an interview on 9/9/19 with Staff B revealed hot food temperatures should be 140 degrees and cold food should be served at 60 degree. The staff indicated that the second group food should have been reheated and temperature checked. During an interview on 9/9/19 with the Program Director confirmed hot food should be served at 140 degree and cold food should be served at 60 degree. Additional interview indicated hot foods should be served within 15 minutes after removal from the stove or oven.	W 473	W473 The facility will ensure that food served to the consumers will be served at the correct temperature at all meals. All staff will be in-serviced on regulations for serving hot foods and when the reheating process will occur. The QP and Habilitation Coordinator will monitor the implementation of this plan of correction a minimum of 3 times monthly and will document findings on LIFE, Inc. QA/QI forms.	11-10-2019

October 3, 2019

Wambui Karanu, RN
Nurse Consultant I
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, North Carolina 27699-2718

Re: Plan of Correction
LIFE, Inc. /Idlewood Group Home

Dear Ms. Karanu,

Enclosed please find our written plan of correction for the recent survey at our Idlewood Group Home.

If there are questions or if additional information is needed, please feel free to contact me.

Thank you for your continuing assistance to us in the operation of our facilities.

Sincerely,

Barbara W. Parker

Barbara W. Parker
Director ICF/IID Services

anw
Enclosure

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Goldsboro, North Carolina 27534
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