

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

PRINTED: 10/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2019
NAME OF PROVIDER OR SUPPLIER LIFE, INC ALBEMARLE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 243 COKE AVENUE EDENTON, NC 27932		
(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	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>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 program consisting of needed interventions and services identified in the individual program plan (IPP) in the area dining skills. This affected 1 of 4 audit clients (#3). The finding is:</p> <p>Client #3 was not prompted to use a knife during meal time.</p> <p>During dinner observations in the home on 10/22/19 from 5:50pm until 5:58pm, client #3 was observed eating two pieces of chicken with his fingers 14 times. Further observations revealed client #3 did not have a knife at his place setting.</p> <p>Review on 10/22/19 of client #3's IPP dated 3/26/19 stated, "...assistance with cutting if needed...." Further review revealed, "I will eat with my hands at times and should be encouraged to use my utensils where appropriate."</p> <p>Review on 10/23/19 of client #3's skills</p>	W 249			

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.

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

PRINTED: 10/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2019
NAME OF PROVIDER OR SUPPLIER LIFE, INC ALBEMARLE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 243 COKE AVENUE EDENTON, NC 27932		
(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 1 assessment dated 3/26/19 revealed he is totally independent with using a knife for cutting and using the appropriate utensil when eating. Review on 10/23/19 of client #3's nursing evaluation dated 3/20/19 revealed he needs assistance with cutting. Review on 10/23/19 of client #3's nutritional evaluation dated 4/10/19 stated, "...assistance in cutting if needed."	W 249			
W 287	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for the convenience of staff. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 4 audit clients (#3) received a technique to manage inappropriate behavior was not used for the convenience of staff. The finding is: The facility failed to ensure a technique to manage the inappropriate behavior of client #3 was not used for the convenience of staff. During evening observations in the home on	W 287			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2019
NAME OF PROVIDER OR SUPPLIER LIFE, INC ALBEMARLE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 243 COKE AVENUE EDENTON, NC 27932		
(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 287	Continued From page 2 10/22/19 at 6:23pm, Staff A told client #3 on two separate occasions to put his hands in his pockets. Further observations revealed client #3 was raising his hand over the top of Staff A. During an interview on 10/22/19, Staff A revealed she told client #3 to put his hands in his pockets because when he "puts his hands up in the air, he might hit a person", so she found out by telling him to put his hands in his pockets prevents him from hitting. Review on 10/22/19 of client #3's behavior intervention program (BIP) dated 5/28/18 stated, "Target Behavior Definition: Inappropriate touching: Touching or attempting to touch others...B. Inappropriate Touching: 1. Whenever [Client #3] is observed touching or attempting to touch or grab other's staff well immediately intervene and give verbal prompt, "[Client #3 no _____ (touching)" and pair physical redirection of his hands to his lap for a minimum of 10 consecutive seconds...."	W 287			
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 observation, record review and interview, the facility failed to ensure the system	W 368			

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

PRINTED: 10/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2019
NAME OF PROVIDER OR SUPPLIER LIFE, INC ALBEMARLE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 243 COKE AVENUE EDENTON, NC 27932		
(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 368	Continued From page 3 of administrating medications as ordered was implemented. This affected 1 of 4 audit clients (#2) The findings are: Client #4 did not receive his Meloxican as ordered. During afternoon observations in the home on 10/22/19 at 3:21pm, Staff A administered client #2 his Meloxican 7.5 milligram tab. Review on 10/23/19 of client #2's physician orders signed 8/12/19 stated, "Meloxican Tab 7.5 mg Take 1 Tablet by Mouth every evening *Take with Food* 8pm."	W 368			
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills were conducted at varied times. This affected all clients residing in the home. The finding is: Fire drills on second and third shifts were not conducted at varied times. Review of fire drill reports on 10/22/19 revealed the following:	W 441			

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

PRINTED: 10/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2019
NAME OF PROVIDER OR SUPPLIER LIFE, INC ALBEMARLE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 243 COKE AVENUE EDENTON, NC 27932		
(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 441	<p>Continued From page 4</p> <p>Four fire drills were conducted on second shift, one at 8pm and the other three at 3:15pm.</p> <p>Five fire drills were conducted on third shift, one at 3:15am and the other four either at 6:15am or 6:30am.</p> <p>During an interview on 10/22/19, the qualified intellectual disabilities professional (QIDP) confirmed the fire drills conducted on both second and third shifts were not varied.</p>	W 441			