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

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

| NAME OF PROVIDER OR SUPPLIER  LIFE, INC COKE AVENUE GROUP HOME  (X4) ID PREFIX TAG  W 000 INITIAL COMMENTS  A revisit was conducted on 10/1-2/19. All deficiencies was been corrected, and no new noncompliance with all regulations surveyed.  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 255 COKE AVE EDENTON, NC 27932  ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  W 000 INITIAL COMMENTS  W 000 INITIAL COMMENTS  A revisit was conducted on 10/1-2/19. All deficiencies have been corrected, and no new noncompliance was found. The facility is in compliance with all regulations surveyed. | STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′   | (X2) MULTIPLE CONSTRUCTION A. BUILDING           |   |   | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|---|--|-------|--|---|---|-------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER  LIFE, INC COKE AVENUE GROUP HOME  (X4) ID PREFIX TAG  (SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 000  INITIAL COMMENTS  A revisit was conducted on 10/23/19 for all previous deficiencies cited on 10/1-2/19. All deficiencies have been corrected, and no new noncompliance was found. The facility is in   |   |   | <b>34G333</b> B. WING  |       |  |   |   |                               |  |
| (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 000 INITIAL COMMENTS  A revisit was conducted on 10/23/19 for all previous deficiencies cited on 10/1-2/19. All deficiencies have been corrected, and no new noncompliance was found. The facility is in  |   |   |  |       | 255 COKE AVE                                     |   | 1 |                               |  |
| A revisit was conducted on 10/23/19 for all previous deficiencies cited on 10/1-2/19. All deficiencies have been corrected, and no new noncompliance was found. The facility is in   | PREFIX  | (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | PREFI | PROVIDER'S F<br>( (EACH CORREC'<br>CROSS-REFEREN | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE |   | COMPLETION                    |  |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE   |   | A revisit was cond previous deficiencies have to noncompliance was compliance with al | ucted on 10/23/19 for all es cited on 10/1-2/19. All peen corrected, and no new is found. The facility is in I regulations surveyed. |       |  |   |   | (Ve) 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.