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

PRINTED: 12/18/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G034	A. BUILDING ______ B. WING ______	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC. WALNUT STREET GROUP HOME	1011 EAST WALNUT STREET GOLDSBORO, NC 27530

(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 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure privacy for 2 of 4 audit clients (#2 and #5) residing in the home. The findings are: Clients #2 and #5 was not afforded privacy while in the home. 1. During afternoon observations in the home on 12/16/19 at 3:37pm, client #2 was escorted into the bathroom by Staff B. Further observations revealed at 3:38pm Staff B pulled down both the pants and disposable brief of client #2; client #2 then sat down on the toilet. At 3:39pm, Staff B removed client #2's pants and disposable brief. Additional observations revealed client #2 standing up off the toilet at 3:41pm and Staff B using personal hygiene wipes to clean between client #2's legs. During this time the bathroom door remained open. At 3:42pm, the qualified intellectual disabilities professional (QIDP) walked by and closed the door. During an interview on 12/16/19, Staff B revealed client #2 relies on staff to close the bathroom door to ensure her privacy during personal care. Review on 12/17/19 of client #2's skills assessment dated 10/21/19 stated she has partial independence with closing the bathroom door for privacy during personal care.	W 130	W 130 The facility will ensure privacy during treatment and care of personal needs, including but not limited to ensuring bathroom door is closed during consumer's personal care. Staff will be in-serviced on maintaining consumer privacy by ensuring bathroom door is closed during consumer's personal care, and on consumers' level of independence in closing bathroom door for privacy. Ongoing compliance with this regulation will be monitored by the QP and Habilitation Coordinator through completion of QA/QI inspections and camera observations, a minimum of 3 times monthly. Findings will be documented on camera observation form and in the Inspection App. DHSR - Mental Health JAN 7 2020 Lic. & Cert. Section	2-15-2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara W. Parker — TITLE: Dir of FCF/IID — (X6) DATE: 1-3-2020

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.

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W 130	Continued From page 1 During an interview on 12/16/19, the QIDP revealed all the staff should be aware of privacy for the clients residing in the home, including client #2. 2. During observations in the home on 12/17/19, Staff A was observed to open the bathroom door and leave it open. Client #5 was sitting on the toilet, her pants positioned halfway down her thighs. Staff A assisted client #5 to stand, and once client #5 was in a standing position, Staff A pulled her pants up. Client #5 began vocalizing and pointing to her backside, and then proceeded to pull her pants down, exposing her backside. Review on 12/17/19 of client #5's skills assessment dated 10/29/19 revealed she is totally independent in closing a bathroom door for privacy. Interview on 12/17/19 with the QIDP revealed that the bathroom door should not have been opened while client #5 was sitting on the toilet, and the door should always be closed when clients are receiving personal care.	W 130		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, record reviews and	W 189		

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W 189	Continued From page 2 interviews, the facility failed to ensure staff were sufficiently trained regarding the locking of client #5's wheelchair. This affected 1 of 4 audit clients. The finding is: Staff were not sufficiently trained regarding the locking of client #5's wheelchair. During morning observations in the home on 12/17/19 at 9:07am, client #5 was being transferred from a chair in the living room to her wheelchair, while getting assistance from Staff A. Further observations revealed client #5's wheelchair rolling backwards as she was being transferred. Additional observations on 12/17/19 at 9:09am, revealed client #5 being transferred from her wheelchair to the van. While being transferred client #5's wheelchair rolled backwards. During both of these transfers, client #5's wheelchair was not locked. During an interview on 12/17/19, Staff A revealed client #5's wheelchair should have been locked for her safety. During an interview on 12/17/19, the facility's nurse confirmed client #5's wheelchair should have been locked "so it doesn't roll" while she is being transferred. Further interview revealed client #5's wheelchair is locked for safety reasons.	W 189	W 189 The facility will ensure that all staff are sufficiently trained regarding locking of consumer's wheelchair to ensure consumer safety, including but not limited to when transferring to/from wheelchair. Staff will be in-serviced by the QP and the nurse to ensure that all staff know how to lock wheelchair to keep it from moving when consumer is transferred to/from wheelchair. Ongoing compliance with this regulation will be monitored by the QP and Habilitation Coordinator when they complete QA/QI inspections a minimum of 3 times monthly. Findings will be documented i n the Inspection App.	2-15-2020
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	W 249		

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W 249	Continued From page 3 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 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 areas of self-help skills, ambulation and dining guidelines. This affected 1 of 4 audit clients (#5). The findings are: 1. During observations throughout the survey on 12/16 - 17/19, client #5's pants were observed to be hanging loose on her hips. Further observations revealed client #5's buttocks and underwear were visible. Client #5 was also observed to be pulling on her pants. Additional observations revealed client #5 was not wearing a belt during both days of the survey. Further observations on 12/17/19 revealed client #5's zipper was down and her underwear were visible. At no time during the survey was client #5 prompted to change her clothing or zip up her pants. Review on 12/17/19 of client #5's IPP dated 10/29/19 stated, "Staff assist me with...zippers....I need help in selecting my clothing...." Review on 12/17/19 of client #5's skills assessment dated 10/9/19 revealed she has partial independence with using zippers and putting on a belt.	W 249	W 249 The facility will ensure each client receives a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of self-help skills, ambulation and dining guidelines, including but not limited to consumer's level of independence in dressing self/putting on a belt. Staff will be in-serviced on consumers' level of independence in dressing self/putting on a belt, on assisting consumers with zippers, buttons, belts, to ensure clothes are fastened appropriately, and on ensuring that consumers have access to clothing (that consumers have belts if needed). Ongoing compliance with this regulation will be monitored by the QP and Habilitation Coordinator when they complete QA/QI inspections a minimum of 3 times monthly. Findings will be documented in the Inspection App.	2-15-2020

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W 249	Continued From page 4 During an interview on 12/17/19, the qualified intellectual disabilities professional (QIDP) stated she was not sure if client #5 ever had a goal on how to use a belt. Further interview revealed client #5 does not have a belt among her personal possessions. The QIDP indicated client #5 relies on staff to ensure the zippers on her pants are pulled up. 2. During afternoon observations in the home on 12/16/19 at 3:57pm, client #5 was observed sitting at the dinning room table eating her snack. Further observations revealed there were no napkins one the table. At 4:16pm, client #5 entered the medication room. Additional observations revealed client #5 had food particles on the side of her chin while sitting and facing the medication technician. The QIDP noticed at 4:26pm, client #5 needed to wipe her mouth and instructed the medication technician to assist client #5 with wiping her mouth. Review on 12/17/19 of client #5's skills assessment dated 10/9/19 revealed she has partial independence with wiping her mouth. During an interview on 12/17/19, the QIDP stated client #5 can wipe her mouth with verbal prompting or hand over hand assistance. 3. Client #5's gait belt was not consistently used. During observations on 12/16/19 at the day program, Staff C was observed to assist client #5 with ambulating around the day program by	W 249	W 249 The facility will ensure each client receives a continuous active treatment program consisting of needed interventions and services identified in the individual program plan (IPP) in the areas of self-help skills, ambulation and dining guidelines, including but not limited to consumer's level of independence in using a napkin to wipe mouth. Staff will be in-serviced on consumers' level of independence in using a napkin to wipe mouth, and ensuring that consumers have access to napkins at mealtime. Ongoing compliance with this regulation will be monitored by the QP and Habilitation Coordinator when they complete QA/QI inspections and mealtime camera observations, a minimum of 3 times monthly. Findings will be documented on camera observation form and in the Inspection App.	2-15-2020

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W 249	Continued From page 5 holding on to client #5's gait belt. Additional observations in the home on 12/16/19 at 4:12pm, client #5 was observed to be walking around in the living room. Staff B was sitting in the living room on the couch, but did not get up to provide client #5 assistance. At 5:12pm, client #5 was observed to walk into the kitchen to sit at the table. Staff B was assisting her by holding her gait belt. Further observations in the home on 12/17/19 from 6:32am to 6:37am revealed client #5 walking from her bedroom to the living room several times. Each time staff assisted by holding her gait belt. At 8:25am, client #5 was observed walking from the kitchen to the bathroom, with Staff A walking behind her, not holding the gait belt. Once client #5 entered the bathroom, she fell face first to the floor. Staff A called Staff C into the bathroom to assist with getting client #5 up, using the gait belt to assist with getting her up from the floor. At 8:32am, client #5 was observed walking out of the bathroom. Staff A was observed walking behind her, not holding the gait belt. After taking several steps, Staff A was observed to hold client #5 from behind, with her hands on the back of client #5's arms. Staff A did not utilize the gait belt. At 8:50am, Staff C told client #5 to go brush her teeth. Client #5 was observed to get up from the couch and walk across the living room. When she got to the doorway leading down the hall, client #5 stumbled. At that time, Staff A got up from the couch and walked behind her. At 8:58am, client #5 was walking down the hallway and Staff C was observed walking with her holding the gait belt.	W 249	W 249 Each client will receive a continuous active treatment program to support the achievement of objectives identified in the individual program plan. This will include recommendations for the use of adaptive equipment. Staff will be in-serviced by the QP and the nurse to ensure that all staff know when/why consumer's gait belt is to be used. QP will have a core team meeting and complete an addendum to client's IPP defining guidelines as to when/why consumer's gait belt is to be used. Consumer's gait belt should be used to assist and protect consumer from losing her balance during times of instability, going down steps, or disembarking vehicles. Gait belt is not to be used to restrict consumer's movement in the group home. Ongoing compliance with this regulation will be monitored by the QP and Habilitation Coordinator when they complete QA/QI inspections and camera observations, a minimum of 3 times monthly. Findings will be documented on camera observation form and in the Inspection App.	2-15-2020

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W 249	Continued From page 6 Review on 12/16/19 of client #5's IPP dated 10/29/19 revealed staff should use client #5's gait belt when assisting her with getting on and off the van, on unlevel surfaces and in unfamiliar areas. Review on 12/17/19 of client #5's record revealed an adaptive and protective equipment approval and consent form that states the equipment is used to assist and protect client #5 from losing her balance. Further review of client #5's record revealed a physical therapy (PT) assessment dated 10/25/16. The PT assessment states that client #5 has a gait belt that staff can be use to assist client #5 during times of instability, going down steps or disembarking vehicles. Interview on 12/17/19 with Staff A revealed that client #5's gait belt is to keep her from falling and should be used when she is falling so staff can assist her to the floor. Staff A stated "I think we are supposed to use it every time she walks. I'm sure we are." Interview on 12/17/19 with the QIDP revealed that staff should be using the gait belt when client #5 is walking on uneven surfaces or if she is feeling unstable. Further interview with the QIDP revealed that if client #5 should fall, staff should use the gait belt to assist her with walking once she is gotten up from the floor. 4. Client #5's meal time guidelines were not followed. During observations on 12/16/19 at the day program, client #5 began eating her lunch at 12:35pm. At 12:43pm, the QIDP asked Staff C how long client #5 had been eating because they can assist her with eating after 10 minutes. Staff	W 249	W 249 Each client will receive a continuous active treatment program in accordance with their needs, strengths and objectives identified in the individual program plan. This will include, but not be limited to, the area of mealtime as it relates to mealtime guidelines on how long consumer should feed herself before staff helps feed her. Staff will be in-serviced on guidelines on consumer's diet order and OT recommendations on mealtime guidelines on how long consumer should feed herself before staff helps feed her. QP will have a core team meeting and complete an addendum to client's IPP defining guidelines on consumer's diet order and OT recommendations on mealtime guidelines on how long consumer should feed herself before staff helps feed her. Mealtime procedures will be monitored by the QP and the Habilitation Coordinator when they complete QA/QI inspections, camera observations, and on-site mealtime monitoring, a minimum of three times monthly. Findings will be documented on camera observation form, mealtime monitoring form, and in the Inspection App.	2-15-2020

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W 249	Continued From page 7 C was observed to feed client #5. Additional observations on 12/16/19 in the home at 5:46pm revealed client #5 began eating her dinner. At 6:08pm, staff began feeding client #5. Additional observations on 12/17/19 in the home revealed that client #5 began eating her breakfast at 7:11am. At 7:33am, Staff C was observed to begin feeding client #5. Review on 12/16/19 of client #5's IPP dated 10/29/19 revealed that client #5 is a slow eater and gets tired; therefore, staff can help to feed her after 30 minutes. Further review of client #5's record on 12/17/19 revealed an occupational therapy (OT) assessment dated 10/17/18, revised 11/18/19. The OT assessment revealed that if client #5 is not finished eating after 30 minutes, but indicates that she wants to continue to eat, staff may provide assistance. Further review of the homes' diet orders dated 11/26/19 revealed that staff can feed client #5 after 30 minutes. Interview on 12/17/19 with the QIDP revealed that she mistakenly said staff can feed client #5 after 10 minutes. The QIDP confirmed staff should wait 30 minutes before assisting client #5.	W 249		
W 374	DRUG ADMINISTRATION CFR(s): 483.460(k)(7) The system for drug administration must assure that drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law.	W 374		

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W 374	Continued From page 8 This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all drugs were packaged and labeled with the name of the person prescribed the medication, with instructions on how to administer the medication and instructions as to how often to administer the medication for 2 of 4 audit clients (#1, #3). The findings are: 1. Client #1's arthritis relief cream was not labeled. During morning medication administration observations in the home on 12/17/19 at 7:15am, client #1's arthritis cream was not labeled. During an interview on 12/17/19, Staff A confirmed client #1's arthritis cream was not labeled. During an interview on 12/17/19, the facility's nurse confirmed client #1's arthritis cream was not labeled. Further interview revealed "staff probably threw the box away." 2. Client #3's label for Ammonium lactate lotion had faded. During morning medication administration in the home on 12/17/19 at 7:58am, client #3's label for Ammonium lactate lotion was faded and information was unable to be read. During an interview on 12/17/19, Staff A confirmed client #3's Ammonium lactate lotion was faded. During an interview on 12/17/19, the qualified	W 374	W 374 The facility will ensure that drugs are packaged and labeled in accordance with state law. The RN will ensure that all medications for all clients are packaged and labeled with the name of the person prescribed the medication, with instructions on how to administer the medication, and instructions as to how often to administer the medication. The RN will ensure that medication package labels are easy to read to ensure medication is given to the correct person, in the correct dosage, in the correct manner. Ongoing compliance with this regulation will be monitored by the QP and Habilitation Coordinator through completion of QA/QI inspections, camera observations during med administration, medication monitoring after med administration, and on-site observation during med administration, a minimum of 3 times monthly. Findings will be documented in the Inspection App, on camera observation forms, and on med administration checklist form.	2-15-2020

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W 374	Continued From page 9 intellectual disabilities professional (QIDP) revealed client #3's Ammonium lactate lotion was "very" hard to read.	W 374		
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 interviews, the facility failed to ensure all medications remained locked. The findings are: The medications were left unsecured and unsupervised. 1. During evening medication administration observations in the home on 12/16/19 at 4:14pm, Staff B exited the medication room to escort a client into the medication room. Further observations revealed the cabinet where the medications are stored was left unlocked. During an interview on 12/16/19, Staff B revealed she had been trained to ensure the cabinet where the medications are located should remain locked. During an interview on 12/16/19, the qualified intellectual disabilities professional (QIDP) revealed staff have been trained to ensure the cabinet where the medications are stored is kept locked when they are not being dispensed. 2. During morning medication administration in	W 382	W 382 The facility must keep all drugs and biologicals locked except when being prepared for administration. The QP and the nurse will in-service all staff to ensure that all drugs/biologicals remain locked in the cabinet in the med room, and that the cabinet door will remain locked except when meds are being prepared for administration. Ongoing compliance with this regulation will be monitored by the QP and Habilitation Coordinator through completion of QA/QI inspections, camera observations during med administration, medication monitoring after med administration, and on-site observation during med administration, a minimum of 3 times monthly. Findings will be documented in the Inspection App, on camera observation form, and on med administration checklist form.	2-15-2020

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W 382	Continued From page 10 the home on 12/17/19 at 7:17am, the nurse for the home removed a bubble pack of pills from her unsecured mail box which was hanging on the wall and visible to anyone in the home. Further observations revealed the surveyor had been in the medication room since 6:48am. During an interview on 12/17/19, the facility's nurse revealed the bubble pack of pills was not locked up in the medication cabinet. Further interview revealed "normally staff lock up the medications."	W 382		
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 and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is: A key to the facility's drug storage area were accessible to anyone in the home. During morning medication observations in the home on 12/17/19 at 9:30am, the qualified intellectual disabilities professional (QIDP) went to the bulletin board in the medication room, removed a key which was hanging. Further observations revealed the key which was hanging was the key to the cabinet where the medications are stored. Additional observations revealed the key was assessable to anyone in the home.	W 383	W 383 The facility will ensure that only authorized persons have access to keys to the drug storage area. The medication room key will be kept in a locked box, and only authorized personnel will have the code/key to the locked box. Ongoing compliance with this regulation will be monitored by the QP and Habilitation Coordinator through completion of QA/QI inspections, camera observations during med administration, medication monitoring after med administration, and with on-site observation during med administration, a minimum of 3 times monthly. Findings will be documented in the Inspection App, on camera observation form, and on med administration checklist form.	2-15-2020

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
	34G034	A. BUILDING ______ B. WING ______	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC. WALNUT STREET GROUP HOME	1011 EAST WALNUT STREET GOLDSBORO, NC 27530

(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 383	Continued From page 11 During an interview on 12/17/19, the QIDP revealed the key to the cabinet where the medications are stored should always be on the medication technician.	W 383		
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. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 2 of 4 audit clients (#1, #5) received their modified diets as indicated. The findings are: Clients #1 and #5 did not receive their specially modified diet as indicated. 1. During observations in the home on 12/16/19 at 5:57pm, client #1 was observed to be eating two soft shell tacos for dinner. The taco shells were served whole. At 6:06pm, Staff B was observed to take client #1's plate and begin cutting the soft shell tacos up. Client #1 had consumed more than half of the tacos. Staff B gave client #1 her plate back. The tacos were cut into pieces that were larger than 1 inch in size. Review on 12/17/19 of client #1's individual program plan (IPP) dated 3/5/19 revealed that client #1's is on a regular diet, with her foods being cut into 3/4 to 1 inch pieces. Further review of client #1's IPP revealed that staff are to assist client #1 with cutting her food.	W 460	W460 Each client will receive a continuous active treatment program in accordance with their needs, strengths and objectives identified in the individual program plan. This will include, but not be limited to, the area of mealtime as it relates to consumers' diet orders, OT recommendations on size to cut food, and consumer's level of independence cutting food. Staff will be in-serviced on consumers' diet orders, OT recommendations on size to cut food, and consumers' level of independence cutting food. Mealtime procedures will be monitored by the QP and the Habilitation Coordinator when they complete QA/QI inspections, mealtime camera observations, and on-site mealtime observations a minimum of three times monthly. Findings will be documented on camera observation form, mealtime monitoring form, and in the Inspection App.	2-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 460	Continued From page 12 Review on 12/17/19 of client #1's record revealed an occupational therapy (OT) assessment dated 12/5/17, revised on 11/18/19. The OT assessment revealed that client #1's food should be no larger than 1/2 inches. Interview on 12/17/19 with the qualified intellectual disabilities professional (QIDP) revealed that client #1's current diet order is that foods are cut no larger than 1/2 inches. The QIDP confirmed that the taco shell should have been cut into 1.2 inches pieces. 2. During observations at the day program on 12/16/19, client #5 was observed to be eating lunch. She was eating a bologna sandwich cut into small pieces, wafers and vanilla pudding. Staff C was observed to pour ranch dressing on the bologna sandwich and wafers. The bologna and bread was not moistened with gravy or broth. Interview on 12/16/19 with Staff C revealed that ranch dressing was put on client #5's sandwich and wafers because "she likes ranch dressing on her foods." During observations in the home on 12/16/19 revealed client #5 eating supper. She was eating two soft shell tacos. The tacos were cut into three large pieces. The taco shells were not moistened with gravy or broth. Additional interviews in the home on 12/17/19 revealed client #5 eating breakfast. She was eating a muffin. The muffin was cut into pieces, with majority of the pieces being larger than 1 inch in size. Staff C was observed to pour syrup on client #5's muffin and stated "so it's not dry."	W 460	W460 Each client will receive a continuous active treatment program in accordance with their needs, strengths and objectives identified in the individual program plan. This will include, but not be limited to, the area of mealtime as it relates to consumers' diet orders and OT recommendations on moistening food and size to cut food/sandwiches. Staff will be in-serviced on consumers' diet orders and OT recommendations on moistening food and size to cut food/sandwiches. Mealtime procedures will be monitored by the QP and the Habilitation Coordinator when they complete QA/QI inspections, mealtime camera observations, and on-site mealtime observations a minimum of three times monthly. Findings will be documented on camera observation form, mealtime monitoring form, and in the Inspection App.	2-15-2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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W 460	Continued From page 13 Review on 12/16/19 of client #5's IPP revealed that client #5's diet order is all foods are cut into 1/2 to 3/4 inch pieces, gravy or broth is added to meats and dry foods. Additional review of client #5's record on 12/17/19 revealed an occupational therapy (OT) assessment dated 10/17/18, revised on 11/18/19. The OT assessment reveals that client #5's food should be cut into 1/2 to 3/4 inch pieces. Interview on 12/17/19 with the QIDP revealed that client #5's sandwich and wafers may have been moistened with the ranch dressing. However, the QIDP stated the sandwich and wafers should have been moistened with gravy or broth as indicated by her diet order. The QIDP also stated that the tacos shells should also have been moistened. Further interview with the QIDP confirmed that all of client #5's foods should have been cut into 1/2 to 3/4 inch pieces.	W 460		
W 481	MENUS CFR(s): 483.480(c)(2) Menus for food actually served must be kept on file for 30 days. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food substitutions were documented. The finding is: Food substitutions were not documented. During dinner observations in the home on 12/16/19, the dinner consisted of hamburger helper/taco dinner and green beans. Further observations instead of green beans, collard greens were being substituted.	W 481		

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W 481	Continued From page 14 Review on 12/16/19 of the facility's menu for Monday the dinner was: hamburger helper/taco dinner and green beans. Review on 12/17/19 revealed there was no documentation to indicate the food substitution which occurred at dinner. During an interview on 12/16/19, Staff B revealed there were no green beans so collard greens were being substituted. During an interview on 12/17/19, Staff C confirmed if a food item is being substituted for another food item it should be documented on the menu substitution form which is located in the menu book. During an interview on 12/17/19, the qualified intellectual disabilities professional (QIDP) confirmed the food substitutions which occurred for dinner should have been documented.	W 481	W481 The facility will ensure that menus for food actually served will be kept on file for 30 days. Staff will be in-serviced on following the facility's weekly menu, and documenting food substitutions for meals as needed. Ongoing compliance with this regulation will be ensured by the QP and the Habilitation Coordinator through QA/QI inspections and on-site mealtime monitoring completed a minimum of three times monthly. Findings will be documented on mealtime monitoring form and in the inspection app.	2-15-2020

January 3, 2020

Eugina Barnes, BSW, QMRP
Facility Survey Consultant I
Mental Health Licensure and Certification
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, North Carolina 27699-2718

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

Dear Ms. Barnes:

Enclosed please find our written plan of correction for the recent survey at our Walnut Street 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
Director of ICF/IID Services

anw
Enclosure

2609 Royall Avenue
Goldsboro, North Carolina 27534
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