

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

PRINTED: 03/04/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/27/2020
NAME OF PROVIDER OR SUPPLIER LIFE, INC. WALNUT STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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 000	INITIAL COMMENTS	W 000			
W 186	<p>A revisit was conducted on 2/27/2020 for all previous deficiencies cited on 12/16 17/2019. All deficiencies have not been corrected, and new noncompliance was found during Intake #NC00159812. The facility is not in compliance with all regulations surveyed.</p> <p>DIRECT CARE STAFF CFR(s): 483.430(d)(1-2)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>This STANDARD is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide sufficient direct care staff to manage and supervise 1 of 6 clients (#5) in accordance with their behavior support program (BSP). The finding is:</p> <p>Facility failed to provide adequate direct care staff to monitor newly admitted client (#5) on 3rd shift.</p> <p>During an interview on 2/27/2020, Staff A revealed she does not believe one staff person working on 3rd shift is adequate supervision to prevent client #5 from stealing food. Further interview revealed client #5 is aware there is only one staff working on 3rd shift, so she knows that is her greatest opportunity to steal food from the kitchen. Staff A reported there was an incident where client #5 put her hands around the throat</p>	W 186			

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.

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W 186	<p>Continued From page 1 of the 3rd shift staff person.</p> <p>Review on 2/27/2020 of client #5's behavior data sheet dated 12/11/2019 (5 - 6am) stated, "[Client #5] trying to go towards kitchen I explained to her she could not go into kitchen until morning staff arrives. I escorted her to day room, tried to get her to sit, so I could finish my AM duties. She tried to hit me. I used brief hands down, she snatched away and fell into chair....)." On 12/12/2019 at 4:45am client #5's behavior data sheet revealed, "While assisting [Client #5] with grooming, she threw one of her quick punches. I used brief hands down (approx. 1 min.). I asked her to calm down, she tried to snatch out and then kicked me. I asked her to please clam down and she relaxed." Additional review of client #5's behavior data sheet dated 1/6/2020 (7 - 9am) stated, [Client #5] woke up and was prompted back to bed. She charged staff was prompted to return to bed. Again [Client #5] proceeded to put hands around staffs throat, scratch and pull staffs shirt."</p> <p>Review on 2/27/2020 of client #5's BSP dated 1/7/2020 revealed the following target behaviors, "Defiance, Stealing, Aggression and Posterior Cerebellar Artery Syndrome (PICA)."</p> <p>During an interview on 2/27/2020, the home manager revealed 3rd shift has had concerns about their safety while working with client #5; seeing there is only one staff person working on 3rd shift. Further interview revealed the concerns of 3rd shift have been bought up in their safety meetings, but "it didn't go anywhere."</p> <p>During an interview on 2/27/2020, the qualified intellectual disabilities professional (QIDP)</p>	W 186			

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W 186	Continued From page 2 revealed there has been concerns about staff safety when client #5 first was admitted into the facility. Additional interview revealed the QIDP had heard staff "talk" about safety while working with client #5. The QIDP stated there "might" need to be an extra staff person working on 3rd shift.	W 186			
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, interviews and record reviews, the facility failed to ensure 1 of 6 audit clients (#5) received a continuous active treatment program consisting of needed interventions and services as identified in the individual program plan (IPP) in the area of meaningful activities. The finding is: Client #5 was not encouraged to participate in leisure/group activities. During observations in the home on 2/27/2020 from 7:00am to 7:20am, client #5 was observed to sit in the living room chair, unengaged in any leisure activities. At 7:20am, Staff B asked client #5 and two peers to go into the kitchen. From	W 249			

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W 249	<p>Continued From page 3</p> <p>7:20am until 8:00am, client #5 was observed to sit in a chair off to the side while one of peers assisted Staff B with meal preparation. Client #5 was not prompted to assist with meal preparation or engage in a meaningful activity. Additional observations in the home from approximately 8:30am to 9:00am revealed client #5 sitting in the chair in the living room. Client #5 was crying out. Staff A was sitting on the couch but was not prompting client #5 to participate in a leisure activity. At 9:00am, Staff B gave client #5 an iPad.</p> <p>Review on 2/27/2020 of client #5's individual program plan (IPP) dated 12/18/2019 revealed that client #5 needs assistance choosing which activities she wants to participate in, and should be given the choice to select her preferred activities.</p> <p>Interview on 2/27/2020 with the qualified intellectual disabilities professional (QIDP) confirmed that client #5 requires assistance with choosing preferred activities and should be engaged in activities of her choice.</p>	W 249			