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

PRINTED: 12/20/2019
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
	34G346	A. BUILDING ______ B. WING ______	12/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC KING STREET GROUP HOME	117 KING STREET HALIFAX, NC 27839

(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	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, record review and interviews, the facility failed to assure a pattern of interactions consistently supported the individual program plan (IPP) specifically in the area of behavior program implementation. This affected 1 of 3 audit clients (#4). The finding is: Client #4's behavior program was not consistently implemented as written. During observations on 12/17/19 at 4:30pm, client #4 sat down in the floor between the dining table and the kitchen area. She did so in an act of refusal when asked to prepare to receive her medications. Staff A walked away client #4 after she dropped in noncompliance on the floor. All other staff including the habilitation coordinator (HC) and the qualified intellectual disability professional (QIDP) went over to client #4 and continued to prompt her to get up. The HC, QIDP and staff B stood around client #4 looking at her and periodically making eye contact with her as she sat in the floor. The HC told her, "I know what you want, you want my hair." Then, the HC signed to her that it was time to take her	W 249	W 249 The facility will ensure all staff will be re-inserviced on each consumer's current behavior plan. This plan of correction will be monitored on an ongoing basis by the QP and Habilitation Coordinator through monthly inspection a minimum of 3 times per month DHSR - Mental Health JAN 6 2020 Lic. & Cert. Section	2-15-2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara W. Parker
TITLE: QMRP/IDD (handwritten)
(X6) DATE: 1-3-20

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 249	Continued From page 1 medications. Within one minute Staff B signed to her telling her to come on and take her meds. Then Staff A came up and held out her hand to client #4. Client #4 refused to respond to continuous gestures and actions from staff until 4:58pm when staff B signed to her telling her it was time to eat. Client #4 then went into the medication room to take her medicine. Review on 12/17/19 of client #4's IPP dated Nov 14, 2019 revealed that she has an ongoing behavior program to address non-compliance. Further review on 12/18/19 revealed this program (BEH 013) was implemented 9/14/18 and notes that if client #4 is "refusing to participate by falling to the floor", staff will verbally and gesturally prompt her to get up and then allow one minute for her to comply. If she does not comply, the plan notes that staff will "ignore as long as she is safe, by not talking to her or giving her eye contact." Interview with staff A on 12/17/19 revealed that the behavior program calls for client #4 to be ignored when she falls on the floor in non-compliance. Further interview with the QIDP confirmed the behavior program is current but she indicated that the task was essential and that perhaps other components may need to be added to the program.	W 249		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.	W 369		

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W 369	Continued From page 2 This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure all medications were given without error. This affected 1 of 3 audit clients (#1). The finding is: Client #1's eye drops were not administered as ordered. During observations on 12/18/19 at 7:25am, client #1 was given 3 drops of Timolol MAL SOL .5% in her left eye and one drop in her right eye. Review on 12/18/19 of client #1's current physician orders dated 10/30/19 revealed she should receive 1 drop of Timolol MAL SOL .5% "in each eye daily." Interview on 12/18/19 with the nurse confirmed that client #1 should have received one drop of TimololMAL SOL .5% in each eye not three in the left eye.	W 369	W 369 All medications will be administered without error and given as ordered by the physician. Each staff will receive additional training through Life, Inc. medication administration review packet. This plan of correction will be monitored on an ongoing basis by the facility Nurse, QP, and Habilitation Coordinator through scheduled inspections which will be completed a minimum of 3 times per month and documented in the inspection app.	2-15-2020
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 1 of 3 audit clients (#3) was trained in how to care for her own	W 436		

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W 436	Continued From page 3 eye glasses independently. The finding is: Client #3's eye glasses were kept by staff in the medication room. During observation on 12/18/19 at 6:30am, staff obtained client #3's eyeglasses from the locked medication room and handed them to her. Interview with staff C as to why the eye glasses were kept there revealed client #3 just hands them to staff to put in there each night. Staff D stated the same. Review on 12/17 and 12/18/19 of client #3's individual program plan (IPP) dated 1/10/19 revealed no training in how to care for her eye glasses independently. Review of her last eye exam revealed she received eye glasses on 1/7/19. Interview with client #3 confirmed she asks staff to put her eye glasses up for her. However, when asked if she would like to learn to care for them herself, she indicated yes. Interview on 12/18/19 with the QIDP revealed that client #3's eye glasses are just kept in the med room for her by her choice. She also confirmed client #3 has not been trained in how to care for her glasses herself.	W 436	W 436 The facility will ensure that all consumers receive continuous support as it relates to the proper usage of eyeglasses. The Interdisciplinary team will meet and discuss proper usage of eyeglasses. Each staff will be in-serviced to ensure that prescribed eyeglasses are available to the consumer and not locked up at any given time. Objective training will be used to help each consumer learn how to properly use eyeglasses. This plan of correction will be monitored on an ongoing basis by the facility Nurse, QP, and Habilitation Coordinator through scheduled inspections will be completed a minimum 3 times per month and documented in the inspection app.	2-15-2020

January 3, 2020

Joy Alford
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. / King Street Group Home

Dear Ms. Alford:

Enclosed please find our written plan of correction for the recent survey at our King 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
Phone: (919) 778-1900 Fax: (919) 778-1911

Website: www.lifeincorporated.com
Email: info@lifeincorporated.com