STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G286	A. BUILDING _____ B. WING _____	01/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREY FOX RUN GROUP HOME	312 GREY FOX RUN NEWPORT, NC 28570

(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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure that 1 of 4 audited clients (#4) was afforded dignity regarding the use of disposable incontinence pads in wheelchair. The finding is: Client #4 was not afforded the right to dignity regarding the use of incontinence pads. During observations at the day program on 1/6/2020 at 11:20 am, client #4 was sitting in his wheelchair in the dining area with other clients, with a cloth and blue disposable incontinence pads, underneath his bottom. An additional observation in the home, on 1/6/2020 at 5:20 pm revealed that client #4 was rolled back into the living room, after finishing dinner by Staff A. Underneath his bottom, was a blue disposable incontinence pad, that was not present when he sat on the wooden dining room chair. Review on 1/7/2020 of client #4's individual program plan (IPP) dated 12/19/2018, revealed that he toilet independently with assistance from staff to get on/off of the toilet. Client #6 had occasional accidents and needed verbal prompts from staff for toileting. During interview with the qualified intellectual disabilities professional (QIDP) on 1/7/2020, she	W 125	W 125 Staff will be in serviced on client's rights. This will include specific training on clients right to dignity. Facility managers will monitor at least 4 times monthly and documentation will occur via LIFE, Inc. QA/QI inspection forms. DHSR - Mental Health JAN 30 2020 Lic. & Cert. Section	3-7-2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Barbara W Parker — TITLE: Dir of ICF — (X6) DATE: 1-28-2020

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 125	Continued From page 1 indicated that staff had been previously told to not use the disposable incontinence pads.	W 125		
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 staff interviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program program (IPP) in the area of adaptive orthotic equipment for 1 of 4 audit clients (#2). The finding is: Staff did not assist client #2 with wearing high top shoes with orthotic supports. During observations in the home and day program, throughout the survey 1/6/2020-1/7/2020, client #2 did not wear high top shoes to support orthotics. During review on 1/6/2020 of client #2's physical therapy evaluation dated 7/28/2009, it indicated that client #2 had pes planus deformity with pronation of forefeet secondary to reduced medial longitudinal arches (MLA), flat foot dysfunction.	W 249	W 249 Facility will ensure that each client receives continuous active treatment to include the needed interventions and services to support the achievement of the specific objectives, independence in relations to strengths, and assistance in regards to needs as outlined in their IPP. This will specifically include ensuring that all clients have the adaptive equipment needed. Staff will receive updated in-service specific to the needs of each client, including but not limited to adaptive equipment utilization. Facility managers will monitor at least 4 times monthly and documentation will occur via LIFE, Inc.'s QA/QI inspection forms.	3-7-2020

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W 249	Continued From page 2 He had true limb discrepancy of 3/8" on the right side. It was recommended that he use custom molded inserts to correct skeletal variation. An additional review on 1/6/2020 of client #2's IPP dated 12/19/2018, revealed that he ambulated with a limp and used inserts in high top shoes. An interview on 1/7/2020 with the qualified intellectual disabilities professional (QIDP) indicated that staff were supposed to have client #2 use his orthotics daily.	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. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure all medications were administered without error. This affected 1 of 3 clients (#3) observed receiving medications. The finding is: Client #3's medications were not administered as ordered. During observations of medication administration in the home on 1/6/2020 at 3:35pm, Staff B assisted client #3 to ingest depakote 250mg. The medication was crushed and mixed with applesauce before client had it. Review on 1/7/2020 of client #3's physician's	W 369	W 369 The Facility will ensure all medications will be administered without error, and given as ordered by the physician. All Staff will be in-serviced on proper medication administration techniques to ensure that all clients in the facility receives prescribed medications as ordered by the physician. The facility managers and/or the RN will monitor at least twice a month to ensure future compliance with this regulation. Documentation of this monitoring will be recorded via LIFE, Inc.'s QA/QI Forms.	3-7-2020

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W 369	Continued From page 3 orders dated 1/29/2020 revealed orders for Depakote 250 mg, Take one tablet by mouth at 3:00pm, *DO NOT CRUSH* Interview on 1/7/2020 with the Staff B confirmed client #3 depakote was crushed since he consumes pureed diet. Interview on 1/7/2020 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #3's Depakote XR should be taken whole. Further interview with the faclility's nurse (via phone) confirmed client #3's Depakote should not be crushed.	W 369		
W 418	CLIENT BEDROOMS CFR(s): 483.470(b)(4)(ii) The facility must provide each client with a clean, comfortable mattress. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure client #3 had a comfortable mattress. This affected 1 of 3 audit clients. The finding is: Client #3 was in need of a new mattress. During observations in the group home on 1/8/2020, client #3's mattress was noted to have an indentation or dip in the middle. During an interview on 1/8/2020, the facility's home manager acknowledged the mattress had a noticeably large dip or sink in the middle. During an interview on 1/8/2020 with the qualified	W 418	W 418 The Facility will ensure each client have a clean, comfortable mattress. All mattresses will be maintained in good repair. When a new mattress is needed, a work order will be submitted to the Director of Facilities. Facility managers will monitor and document findings re: condition of all client's mattresses through use of LIFE, Inc. QA/AI forms at least once a month.	3-7-2020

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W 418	Continued From page 4 intellectual disabilities professional (QIDP) and program coordinator confirmed the mattress had a dip in the middle.	W 418		

January 27, 2020

Esther Moore, BSW, QIDP
Facility Compliance Consultant I
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Re: Plan of Correction
LIFE, Inc. Grey Fox Group Home

Dear Miss. Moore,

Enclosed please find our written plan of correction for the recent survey at our Grey Fox 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

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

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Email: info@lifeincorporated.com