STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G339	A. BUILDING _____ B. WING _____	11/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC BEAUFORT HEIGHTS GROUP HOME	103 CIRCLE STREET WASHINGTON, NC 27889

(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 A recertification survey and complaint survey was completed on 11/24/20 for intake #NC00171771 and intake #00171836. Deficiencies were cited.	W 000		
W 127	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(5) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 6 clients (#2) residing in the home was not subject to physical, verbal and psychological abuse or punishment. The finding is: Review on 11/23/20 of the facility's incident report dated 11/16/20 revealed an altercation occurred on 11/16/20 between Staff A and client #2. Client #2 was displaying behaviors from approximately 4:30pm until 9:15pm. Prior to dinner time in the home, client #2 was displaying behaviors which was agitating his peers. Staff in the home asked client #2 to leave his peers alone, but he became more angry and upset with the staff, calling them names, cursing, etc. During medication administration, Staff A and client #2 were in the med room when client #2 began displaying more behaviors and refusing to take his medications. Staff A asked client #2 to leave the medication room, but he refused. Staff A physically assisted client #2 out of the medication room and once they were in the hallway, client #2 punched Staff A in the face. Staff A ran behind the client, hitting	W 127	W127 The facility will ensure that consumers are no subjected to physical, verbal, sexual or psychological abuse or punishment by re-in-servicing all staff on how to handle behaviors appropriately. Staff will also be re-in-serviced on promotion of consumer well-being, to include reporting procedures with emphasis on self-reporting. In-servicing on promotion of consumer well-being and reporting procedures will begin on 11/24/20. Behavioral Intervention Programs will also begin on 11/24/2020. The accused staff will be issued immediate disciplinary action in the form of termination. Staff who failed to report incident, at the time of occurrence, will be issued disciplinary action as well. When investigations occur, proper monitoring will be done to ensure that all consumers are free from physical, verbal, sexual, or psychological abuse or punishment. Concerns will be addressed immediately, and follow-up documentation will be indicated on LIFE, Inc's Formal Inquiry form. Weekly QA/QI inspections will be conducted in addition to weekly camera observations to observe staff/client interactions. Camera observations will be documented on LIFE, Inc. Camera Observation form. Any additional follow-up documentation will be included as well; investigative statement, accident/injury reports, NC IRIS documentation, and disciplinary action forms.	1/8/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Barbara W. Parker	Dir. of TCF	1-20-2021

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.

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

PRINTED: 11/30/2020
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OMB NO. 0938-0391

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

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 127	Continued From page 1 him in the back. Review on 11/23/20 of the facility's investigation initiated on 11/18/20 and completed on 11/20/20 revealed that on 11/16/20, client #2 was displaying continuous behaviors from approximately 4:30pm until approximately 9:15pm. Staff A and client #2 were in the medication room when client #2 became more agitated, and refused to take his medications. Staff A physically assisted client #2 out of the medication room. Additional review of the facility's investigation revealed once they were in the hallway, client #2 punched Staff A in the face. Staff A and other staff in the home contacted the facility nurse to request crisis medication for client #2, as well as report Staff A being injured from client #2 punching her in the face. The facility nurse contacted the qualified intellectual disabilities professional (QIDP). The QIDP contacted Staff A regarding her injuries and Staff A requested to go home, and the QIDP allowed this. Further review of the facility's investigation revealed that on 11/18/20, the QIDP reviewed camera footage in the home. At the time of the review of the camera footage, it was observed that after client #2 was punched in the face, Staff A ran behind client #2 down the hall, hitting him four times in the back. Based on this observation, the QIDP initiated the investigation. Staff A was suspended until the conclusion of the investigation. Review on 11/23/20 of Staff A's written statement revealed that while in the medication room, client #2 refused to take his medication. Staff A asked	W 127		

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W 127	Continued From page 2 client #2 to leave the room so another client could come in. Client #2 tried to slam the door, while Staff A was trying to open the door. Staff A stated "Go ahead, go ahead now." Once outside the doorway, client #2 punched her in the face. When client #2 punched Staff A in the face, Staff A reported she ran behind him but did not recall hitting him. Staff A reported that client #2 grabbed a picture off the wall and was about to hit her with it when Staff B intervened. Review on 11/23/20 of Staff B's written statement dated 11/17/20 revealed that at approximately 9:00pm, client #2 was in the medication room. Staff A was trying to get client #2 out of the medication room. Client #2 punched Staff A in the face, and ran down the hall. Staff A ran behind client #2 and pushed him into the wall, causing a picture to fall off the wall. Client #2 picked up the picture and tried to throw it at Staff A, but Staff B reported he intervened, grabbed the picture and redirected client #2 to his bedroom. Review on 11/23/20 of Staff C's written statement dated 11/17/20 revealed that client #2 became upset with Staff A when she asked him to keep his hands to himself due to practicing social distancing. Client #2 went into his bedroom, turned his music up loudly, and broke some glass. He came into the kitchen and was staring at Staff A. After dinner, client #2 was calling Staff A names and giving her the middle finger. Staff C reported that when she came around the corner, she observed Staff A and client #2 "tussling." Staff A pushed client #2 away from her and Client #2 punched Staff A in the face. At that time, Staff A pushed client #2 into the wall and client #2 picked up the wall art to hit Staff A with.	W 127		

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W 127	Continued From page 3 Review on 11/24/20 at 9:30am with the QIDP, Habilitation Coordinator and facility nurse of the camera footage revealed Staff A and client #2 in the medication room. Client #2 was refusing to take his medication, and Staff A was attempting to redirect him out of the medication room. Further review of the camera footage revealed Staff A trying to physically assist client #2 out of the room. Once they were outside of the room and in the hallway, client #2 punched Staff A in the face, turned around and started running toward his bedroom. Staff A was observed to run behind him, swinging her arms and appearing to strike client #2 four times on his back. Interview on 11/24/20 with the QIDP revealed that the facilities investigation was concluded on 11/20/20. The QIDP revealed that Staff A received a written warning instead of being terminated for her actions because the facility felt that Staff A was a good employee. The QIDP revealed that Staff A had been working at the facility since 4/20, had a good rapport with the clients, worked whenever she was needed, and felt that it would be wrong to terminate her employment due to this incident and prevent her from being able to work doing what she enjoys. The QIDP confirmed the potential for abuse was still present in the home. Further interview on 11/24/20 with the QIDP revealed the facility planned to provide training to Staff A and all other staff on clients Behavior Intervention Programs (BIP) and on the facility's policy regarding mistreatment, negect and abuse. The QIDP revealed that Staff A's suspension was lifted on 11/20/20, and Staff A returned to work on 11/20/20 and continued to work on 11/21/20 and	W 127		

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W 127	Continued From page 4 11/22/20. At the time of the survey completed on 11/24/20, training had not been provided. Review on 11/24/20 of the facility's Consumer Rights Policy dated 5/2014, revised 5/14/18, revealed a section entitled Promotion of Consumer Well Being and Abuse Prevention describes physical abuse as "any physical action that results in or could potentially result in physical injury to a consumer. Examples include but are not limited to hitting, beating, pinching, kicking, harmful restraint, and use of a weapon or other instrument to inflict bodily harm." In addition, all alleged incidents of rights violations and crimes will be investigated and documented with appropriate corrective actions taken based on findings. Any employee who intentionally abuses a consumer or exploits a consumer's property is guilty of a class 1 misdemeanor. Additional review of the Consumer Rights Policy revealed "Based on findings during the alleged rights violation investigation, appropriate disciplinary action will be taken, including possible termination, as specified in other policies approved and/or adapted by the facility. The facility was notified by the surveyor on 11/24/20 that an immediate jeopardy existed in the facility based on review of staff statements, review of camera footage and the facility bringing the staff back to work which is against their policy. The facility responded with the following plan of protection actions: 1. The facility will ensure that consumers are not subject to physical, verbal, sexual or psychological abuse or punishment by re-inservicing all staff on how to handle behaviors	W 127		

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W 127	Continued From page 5 appropriately. 2. Staff will also be inserviced on promotion of consumer well-being, to include reporting procedures with emphasis on self-reporting to begin on 11/24/20. 3. In-service on BIP's will begin on 11/24/20. 4. Staff A will be issued immediate disciplinary action in the form of termination. 5. Staff B and Staff C will be issued disciplinary action for failing to report the incident at the time of occurrence. After reviewing the plan of protection developed by the facility on 11/24/20, it was determined that the immediate jeopardy was removed. .	W 127		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record reviews and interview, the facility neglected to assure its policies and procedures that prohibit physical abuse were implemented to protect 6 of 6 clients in the home (#1, #2, #3, #4, #5, and #6). The finding is: Review on 11/23/20 of the facilitiy's investigation initiated on 11/18/20 and completed on 11/20/20 revealed that Staff A and client #2 were in the medication room when client #2 became agitated, and refused to take his medications. Staff A physically assisted client #2 out of the medication room. Once they were in the hallway, client #2 punched Staff A in the face. Staff A and other	W 149		

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W 149	Continued From page 6 staff in the home contacted the facility nurse to request crisis medication for client #2, as well as report Staff A being injured from client #2 punching her in the face. The facility nurse contacted the qualified intellectual disabilities professional (QIDP). The QIDP contacted Staff A regarding her injuries and Staff A requested to go home, and the QIDP allowed this. On 11/18/20, the QIDP reviewed camera footage in the home. At the time of the camera footage review, it was observed that after client #2 was punched in the face, Staff A ran behind client #2 down the hall, hitting him four times in the back. Based on this observation, the QIDP initiated the investigation. Staff A was suspended until the conclusion of the investigation. Review on 11/24/20 of the facility's Consumer Rights Policy dated 5/2014, revised 5/14/18, revealed a section entitled Promotion of Consumer Well Being and Abuse Prevention describes physical abuse as "any physical action that results in or could potentially result in physical injury to a consumer. Examples include but are not limited to hitting, beating, pinching, kicking, harmful restraint, and use of a weapon or other instrument to inflict bodily harm." In addition, all alleged incidents of rights violations and crimes will be investigated and documented with appropriate corrective actions taken based on findings. Any employee who intentionally abuses a consumer or exploits a consumer's property is guilty of a class 1 misdemeanor. Additional review of the Consumer Rights Policy revealed "Based on findings during the alleged rights violation investigation, appropriate disciplinary action will be taken, including possible termination, as specified in other policies approved and/or adapted by the facility.	W 149	W149 The facility will ensure that policies and procedures that were developed will be implemented to prohibit mistreatment, neglect, or abuse of the client. Staff will be re-in-serviced on policies and procedures as it relates to mistreatment, neglect, or abuse of the client. Client's will receive annual rights assessment educating them on the right to be free from abuse/neglect/mistreatment. Investigations that occur will be conducted as policy states and reviewed. This will be monitored one time weekly by the facility managers as part of QA/QI inspections and biannually as part of Corporate Compliance interviews. Any follow up documentation will be indicated on LIFE, Inc's Formal Inquiry Form and attached to other internal documentation used but not limited to investigative statement, injury reports, NC IRIS documentation, and disciplinary action forms.	1/8/2021

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W 149	Continued From page 7 Interview on 11/24/20 with the QIDP revealed that the facilitiy's investigation was concluded on 11/20/20. The QIDP revealed that Staff A received a written warning instead of being terminated for her actions because the facility felt that Staff A was a good employee. The QIDP revealed that Staff A had been working at the facility since 4/20, had a good rapport with the clients, worked whenever she was needed, and felt that it would be wrong to terminate her employment due to this incident and prevent her from being able to work doing what she enjoys. The QIDP confirmed the potential for abuse was still present in the home. Further interview on 11/24/20 with the QIDP revealed the facility planned to provide training to Staff A and all other staff on clients Behavior Intervention Programs (BIP) and on the facility's policy regarding mistreatment, negect and abuse. The QIDP revealed that Staff A's suspension was lifted on 11/20/20, and Staff A returned to work on 11/20/20 and continued to work on 11/21/20 and 11/22/20. At the time of the survey completed on 11/24/20, training had not been provided. The facility's Consumer Rights Policy defines neglect as "serious disregard of consumer's supervision, care, or treatment. It is any action by an employee that results in harm/injury or could potentially result in harm/injury to a consumer." Based on review of the facilities investigation dated 11/18/20, review of the facility's Consumer Rights Policy dated 5/2014, revised 5/14/18, and interview with the QIDP on 11/24/20, the facility was neglectful by allowing Staff A, who exhibited physical abuse against a client, to return to work and continue to work in direct contact with all	W 149		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC BEAUFORT HEIGHTS GROUP HOME	103 CIRCLE STREET WASHINGTON, NC 27889

(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 149	Continued From page 8 clients living in the facility.	W 149		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that management was notified immediately of an incident of physical abuse. This affected 1 of 4 audit clients (#2). The finding is: Review on 11/23/20 of the facility's incident report dated 11/16/20 revealed an altercation occurred on 11/16/20 between Staff A and client #2. During medication administration, Staff A and client #2 were in the med room when client #2 began displaying behaviors and refusing to take his medications. Staff A asked client #2 to leave the medication room, but he refused. Staff A physically assisted client #2 out of the medication room and once they were in the hallway, client #2 punched Staff A in the face. Staff A ran behind the client, hitting him in the back. Review on 11/23/20 of the facility's investigation initiated on 11/18/20 and completed on 11/20/20 revealed that on 11/16/20, client #2 was displaying continuous behaviors from approximately 4:30pm until approximately 9:15pm. Staff A and client #2 were in the	W 153	W153 The facility will ensure that all allegations of mistreatment, neglect, or abuse as well as injuries of unknown sources are reported immediately to the administrator or to other officials in accordance with state law through established procedures by re-in-servicing staff on promotion of consumer well-being, client rights, and client's incidents. The training will review current protocol of reporting responsibilities of witnesses. This will be monitored daily by checking consumer's Accident/Incident reports, one time weekly as part of manager's QA/QI inspections, and through biannual documented Corporate Compliance interviews and annual training which will be placed in the employees training files.	1/8/2021

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	34G339	A. BUILDING _____ B. WING _____	11/24/2020

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W 153	Continued From page 9 medication room when client #2 became more agitated, and refused to take his medications. Staff A physically assisted client #2 out of the medication room. Once they were in the hallway, client #2 punched Staff A in the face. On 11/18/20, the QIDP reviewed camera footage in the home. At the time of the review of the camera footage, it was observed that after client #2 was punched in the face, Staff A ran behind client #2 down the hall, hitting him four times in the back. Based on this observation, the QIDP initiated the investigation. Staff A was suspended until the conclusion of the investigation. Review on 11/23/20 of Staff A's written statement revealed that while in the medication room, client #2 refused to take his medication. Staff A asked client #2 to leave the room so another client could come in. Client #2 tried to slam the door, while Staff A was trying to open the door. Staff A stated "Go ahead, go ahead now." Once outside the doorway, client #2 punched her in the face. When client #2 punched Staff A in the face, Staff A reported she ran behind him but did not recall hitting him. Staff A reported that client #2 grabbed a picture off the wall and was about to hit her with it when Staff B intervened. Review on 11/23/20 of Staff B's written statement dated 11/17/20 revealed that at approximately 9:00pm, client #2 was in the medication room. Staff A was trying to get client #2 out of the medication room. Client #2 punched Staff A in the face, and ran down the hall. Staff A ran behind client #2 and pushed him into the wall, causing a picture to fall off the wall. Client #2 picked up the picture and tried to throw it at Staff A, but Staff B reported he intervened, grabbed the picture and redirected client #2 to his	W 153		

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W 153	Continued From page 10 bedroom. Review on 11/23/20 of Staff C's written statement dated 11/17/20 revealed that client #2 became upset with Staff A when she asked him to keep his hands to himself due to practicing social distancing. Client #2 went into his bedroom, turned his music up loudly, and broke some glass. He came into the kitchen and was staring at Staff A. After dinner, client #2 was calling Staff A names and giving her the middle finger. Staff C reported that when she came around the corner, she observed Staff A and client #2 "tussling." Staff A pushed client #2 away from her and Client #2 punched Staff A in the face. At that time, Staff A pushed client #2 into the wall and client #2 picked up the wall art to hit Staff A with. Review on 11/24/20 at 9:30am with the QIDP, Habilitation Coordinator and facility nurse of the camera footage revealed Staff A and client #2 in the medication room. Client #2 was refusing to take his medication, and Staff A was attempting to redirect him out of the medication room. Further review of the camera footage revealed Staff A trying to physically assist client #2 out of the room. Once they were outside of the room and in the hallway, client #2 punched Staff A in the face, turned around and started running toward his bedroom. Staff A was observed to run behind him, swinging her arms and appearing to strike client #2 four times on his back. Review on 11/24/20 of the facility's Consumer Rights Policy dated 5/2014, revised 5/14/18, revealed a section entitled Promotion of Consumer Well Being and Abuse Prevention which states "All employees of the facility will receive initial training on promotion of consumer	W 153		

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W 153	Continued From page 11 well being and abuse prevention. Training will be provided annually to all employees providing direct services and care to consumers to ensure the provision of quality care and prevention of abuse, neglect and mistreatment." Additional review of the policy revealed a section entitled Consumer Rights Violence which states "All employees are expected to immediately report any alleged or witnessed incidents of rights violations and suspected abuse, neglect or exploitation of persons served. Failure to report is a class 3 misdemeanor punishable by a fine. Reports of the this nature should be directed to someone in a supervisory capacity role in order to ensure that immediate action is taken." Interview on 11/24/20 with the QIDP confirmed that based on the written statements of Staff B and Staff C, they should have immediately reported their observations based on the facilities Consumer Rights Policy.	W 153		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an incident of physical abuse was thoroughly investigated. This affected 1 of 4 audit clients (#2). The finding is: Review on 11/23/20 of the facility's incident report dated 11/16/20 revealed an altercation occurred on 11/16/20 between Staff A and client #2. During medication administration, Staff A and	W 154		

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W 154	Continued From page 12 client #2 were in the med room when client #2 began displaying behaviors and refusing to take his medications. Staff A asked client #2 to leave the medication room, but he refused. Staff A physically assisted client #2 out of the medication room and once they were in the hallway, client #2 punched Staff A in the face. Staff A ran behind the client, hitting him in the back. Review on 11/23/20 of the facility's investigation initiated on 11/18/20 and completed on 11/20/20 revealed that on 11/16/20, client #2 was displaying continuous behaviors from approximately 4:30pm until approximately 9:15pm. Staff A and client #2 were in the medication room when client #2 became more agitated, and refused to take his medications. Staff A physically assisted client #2 out of the medication room. Once they were in the hallway, client #2 punched Staff A in the face. Staff A and other staff in the home contacted the facility nurse to request crisis medication for client #2, as well as report Staff A being injured from client #2 punching her in the face. The facility nurse contacted the qualified intellectual disabilities professional (QIDP). The QIDP contacted Staff A regarding her injuries and Staff A requested to go home, and the QIDP allowed this. On 11/18/20, the QIDP reviewed camera footage in the home. At the time of the camera footage review, it was observed that after client #2 was punched in the face, Staff A ran behind client #2 down the hall, hitting him four times in the back. Based on this observation, the QIDP initiated the investigation. Staff A was suspended until the conclusion of the investigation. Review on 11/23/20 of Staff A's written statement revealed that while in the medication room, client	W 154	W154 The facility must have evidence that all alleged violations are thoroughly investigated. Managers will comprise an investigative team. QP will make necessary contacts to local DSS, Sheriff Department, HRC members, and guardians as well as thoroughly investigate allegations by collecting and carefully reviewing staff and consumer statements, reviewing camera footage (if available), providing proper monitoring of consumers, and concluding investigations based on the consumer health and safety. Investigations will be monitored/forwarded to the Director of Advocacy as they occur. The Quality Assurance and Improvement Team will review all Documentation related to investigations. This will allow for follow-up decisions to be reviewed by a number of clinicians. All documentation will be included on LIFE, Inc's Formal Inquiry form as reviewed as needed during and future investigations.	1/8/2021

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W 154	Continued From page 13 #2 refused to take his medication. Staff A asked client #2 to leave the room so another client could come in. Client #2 tried to slam the door, while Staff A was trying to open the door. Staff A stated "Go ahead, go ahead now." Once outside the doorway, client #2 punched her in the face. When client #2 punched Staff A in the face, Staff A reported she ran behind him but did not recall hitting him. Staff A reported that client #2 grabbed a picture off the wall and was about to hit her with it when Staff B intervened. Review on 11/23/20 of Staff B's written statement dated 11/17/20 revealed that at approximately 9:00pm, client #2 was in the medication room. Staff A was trying to get client #2 out of the medication room. Client #2 punched Staff A in the face, and ran down the hall. Staff A ran behind client #2 and pushed him into the wall, causing a picture to fall off the wall. Client #2 picked up the picture and tried to throw it at Staff A, but Staff B reported he intervened, grabbed the picture and redirected client #2 to his bedroom. Review on 11/23/20 of Staff C's written statement dated 11/17/20 revealed that client #2 became upset with Staff A when she asked him to keep his hands to himself due to practicing social distancing. Client #2 went into his bedroom, turned his music up loudly, and broke some glass. He came into the kitchen and was staring at Staff A. After dinner, client #2 was calling Staff A names and giving her the middle finger. Staff C reported that when she came around the corner, she observed Staff A and client #2 "tussling." Staff A pushed client #2 away from her and Client #2 punched Staff A in the face. At that time, Staff A pushed client #2 into the wall and client #2	W 154		

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W 154	Continued From page 14 picked up the wall art to hit Staff A with. Review on 11/24/20 at 9:30am with the QIDP, Habilitation Coordinator and facility nurse of the camera footage revealed Staff A and client #2 in the medication room. Client #2 was refusing to take his medication, and Staff A was attempting to redirect him out of the medication room. Further review of the camera footage revealed Staff A trying to physically assist client #2 out of the room. Once they were outside of the room and in the hallway, client #2 punched Staff A in the face, turned around and started running toward his bedroom. Staff A was observed to run behind him, swinging her arms and appearing to strike client #2 four times on his back. Review on 11/24/20 of the facility's Consumer Rights Policy dated 5/2014, revised 5/14/18, revealed a section entitled Promotion of Consumer Well Being and Abuse Prevention describes physical abuse as "any physical action that results in or could potentially result in physical injury to a consumer. Examples include but are not limited to hitting, beating, pinching, kicking, harmful restraint, and use of a weapon or other instrument to inflict bodily harm." In addition, all alleged incidents of rights violations and crimes will be investigated and documented with appropriate corrective actions taken based on findings. Any employee who intentionally abuses a consumer or exploits a consumer's property is guilty of a class 1 misdemeanor. Additional review of the Consumer Rights Policy revealed "Based on findings during the alleged rights violation investigation, appropriate disciplinary action will be taken, including possible termination, as specified in other policies approved and/or adapted by the facility.	W 154		

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W 154	Continued From page 15 Interview on 11/24/20 with the QIDP revealed that the facility's investigation was concluded on 11/20/20. The QIDP revealed that Staff A received a written warning instead of being terminated for her actions because the facility felt that Staff A was a good employee. The QIDP revealed that Staff A had been working at the facility since 4/20, had a good rapport with the clients, worked whenever she was needed, and felt that it would be wrong to terminate her employment due to this incident and prevent her from being able to work doing what she enjoys. The QIDP confirmed the potential for abuse was still present in the home. In addition, the QIDP confirmed that Staff B and Staff C should have reported the incident immediately after witnessing it.	W 154		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. 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 and #3) were afforded consistent opportunities for choice and freedom of movement in their environment. The findings are: A. Client #1 was not provided freedom of movement in his home. During observations in the home on 11/23/20 through 11/24/20, client #1 was observed sitting in his bedroom. Each time client #1 would walk from his bedroom to the living area, staff would	W 247		

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W 247	Continued From page 16 tell him "No, you aren't bullying anyone today. Go back to your room." Additional observations in the home revealed client #1 sitting in the living room on the couch or at the table. When client #1 would stand up, staff would say to him "Sit back down or go to your room. No bullying today." Review on 11/24/20 of client #1's individual program plan (IPP) dated 4/30/20 revealed a behavior objective which states "Across all settings, [client #1] will reduce the frequency of defined tantrum behaviors to 6 or less per month for 8 consecutive months." Review on 11/24/20 of client #1's Behavior Intervention Program (BIP) dated 4/30/20 revealed identified target behaviors consisting of vocal agitation, aggression, self-abusive behavior and defiance. "Bullying" was not identified as a target behavior. Interview on 11/24/20 with the qualified intellectual disabilities professional (QIDP) revealed if client #1 was displaying any of his identified target behaviors, redirection to his bedroom would be appropriate. The QIDP confirmed that client #1 should have been able to move freely around his home. B. Client #3 was not afforded the consistent opportunity for choice. During observations in the home on 11/23/20 through 11/24/20, client #3 was observed sitting on the couch in the living room, rocking back and forth. Throughout the observations, staff were observed to tell client #3 to "stop rocking, you are too noisy" or "you are too loud, go to your	W 247	W247 The individual program plan must provide opportunities for client choice and self-management. Staff will be re-in-serviced on consumer's IPP emphasizing consumer's interests and dislikes, in addition to not restricting individual's movement within their living environment. Any restrictions in place will be reviewed with staff and documented on LIFE, Inc training form. Any suggestion for restrictions will need to be submitted and approved by Program Specialist in conjunction with client's guardian and HRC members. Clients will be involved in quarterly house meeting to review likes and dislikes. Any new interests and dislikes will be added to the consumers IPP as we are made aware, staff will also be in-serviced. Consumers will be afforded choice of activities, events, etc., by providing input when creating the activity calendar. This will be monitored by facility managers each day they work utilizing daily scheduled observations & weekly QA/QI inspections; to include meal observations. Monitoring will occur annually during routine in-services.	1/8/2021

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W 247	Continued From page 17 bedroom and rock." Review on 11/23/20 of client #3's IPP dated 3/17/20 revealed client #3 has a diagnosis of Autism. Interview on 11/24/20 with the QIDP revealed that rocking back and forth is considered a possible self-stimulating behavior for client #3. The QIDP revealed that client #3 has a rocking chair in his bedroom that he enjoys rocking in. The QIDP revealed that if client #3 is rocking hard and making loud noises, he could potentially agitate some of his peers in his home. If this occurs, staff should prompt client #3 to go to his bedroom to sit in his rocking chair. The QIDP confirmed that if none of client #3's peers are bothered by him rocking in the living room and the noise from the plastic on the couch, he should be allowed to stay in the living room and rock.	W 247		
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 interview, the facility failed to ensure 1 of 4 audit clients (#4) received a continuous active	W 249	W249 Facility will ensure that continuous active treatment programs consisting of needed interventions and services in sufficient number and frequency to support the achievement of specific objectives in relation to assistance in regard to needs as outlined in their IPP as it relates to behavioral programs. Staff will be re-in-serviced on consumer behavior programs, redirection, and proper documentation of behaviors. Data will be monitored on a monthly basis through QP review reports. Monitoring will also occur at least one time weekly by managers using QA/Qi inspections. Addendums to behavior programs will be suggested to Program Specialist for review, if needed.	1/8/2021

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W 249	Continued From page 18 treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of program implementation. The finding is: During observations in the home on 11/23/20 through 11/24/20, client #4 was observed to bang his head on the wall, door and back of the couch, as well as slam his hands onto the table. Throughout the observations, staff were observed to ignore the behavior or call the client's name. Review on 11/23/20 of client #4's individual program plan (IPP) dated 8/6/20 revealed client #4 has a training objective that states "Across all settings, [client #4] will reduce the frequency of defined tantrum behavior episodes to 8 or less per month for 10 consecutive months." Review on 11/24/20 of client #4's BIP dated 10/15/19 revealed identified target behaviors which includes falling to the floor, aggression, self-injurious behavior and property destruction. Self-injurious behavior is defined as hitting himself, banging his head, hitting his body against objects, putting his finger in his nose, etc. Further review of client #4's BIP revealed interventions/consequences for self-injurious behaviors which includes: - Immediately intervene and provide verbal prompt "[Client #4], stop. No...and describe the behavior." If he stops following the verbal prompts, staff should direct him back to the activity at hand and reinforce active participation. - If self-injurious behaviors continue, staff should repeat verbal prompt ([client #4], please stop" while at the same time physically intervening to redirect client #4's hands to his sides for 2-3 seconds.	W 249		

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W 249	Continued From page 19 - Repeat above procedures as often as needed to prevent the behavior. Interview on 11/24/20 with Staff D revealed no interventions are needed as "That's just what [client #4] does." Interview on 11/24/20 with the qualified intellectual disabilities professional (QIDP) revealed that it may be difficult to physically intervene as the behavior may have stopped prior to staff reaching client #4. The QIDP confirmed the staff should be following the interventions as outlined in client #4's BIP and not simply call his name or ignore the behavior.	W 249		

Company name: LIFE, INC.

Phone: (919)778-1900

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Address: 2609 Royall Avenue Goldsboro, NC 27534

To: Justin Foster From: Life Inc. - Ashland Twigg

Fax #: 919 715 8078 Fax #: 919 778 1972

Date: 1/8/2021 # of pages: 20

Message:

Beaufort Heights Plan of Corrections

LIFE INC.
Together, We Shine!