STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G318	A. BUILDING _____ B. WING _____	03/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC WILSON STREET GROUP HOME	1116 WILSON STREET EXTENSION PLYMOUTH, NC 27962

(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 reviews and interviews, the facility failed to ensure 3 of 3 audit clients (#2, #4 and #5) received a continuous active treatment program consisting of needed interventions and services to support objectives identified in the Individual Program Plan (IPP) in the area of meal preparation. The finding is: During observations throughout the survey in the home on 3/8 - 3/9/21, various staff prepared all food and drink items for 3 of 3 meals. No clients were prompted or encouraged to assist with meal preparation tasks. Interview on 3/9/21 with Staff A revealed staff are preparing all of the meals due to the COVID-19 virus and potential cross-contamination. Additional interview indicated this a directive from management. Review on 3/9/21 of client #2's IPP dated 3/24/20 revealed, "I enjoy helping staff with meals." The plan also indicated the client could prepare a powdered beverage.	W 249		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G318	A. BUILDING _____ B. WING _____	03/09/2021

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W 249	Continued From page 1 Review on 3/9/21 of client #4's IPP dated 12/8/20 noted, "I can assist staff in meal preparation...Staff still continue to offer and encourage me. I attempt to use kitchen appliances with staff direction." Review o 3/9/21 of client #5's IPP dated 4/28/20 indicated, "I need assistance from staff in meal preparation..." Interview on 3/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) and Habilitation Coordinator (HC) indicated there were no current COVID-19 cases in the home. Additional interview confirmed none of the clients are assisting with meal preparation tasks due to the COVID-19 virus and the potential for cross-contamination. The QIDP and HC acknowledged clients could be assisting with some meal preparation tasks individually and with the implementation of sanitary practices (i.e. Handwashing).	W 249		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure all staff were sufficiently trained to implement the facility's current COVID-19 visitor screening process. The	W 340		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G318	A. BUILDING _____ B. WING _____	03/09/2021

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W 340	Continued From page 2 finding is: Upon arrival to the home on 3/8/21 at 9:50am and 3/9/21 at 6:15am, staff invited the surveyor into the home. The surveyor's temperature was not taken and no forms were presented for completion. Interview on 3/9/21 with Staff A revealed the COVID-19 visitor screening consisted of a temperature check and completion of questions regarding COVID-19. Review on 3/9/21 of the facility's COVID-19 screening form revealed the following required information and questions to be competed: Name: Date: Temp: 1. Do you have symptoms of fever, dry cough, shortness of breath, body aches? 2. In the past 14 days, have you had contact with any of the following: - Someone with confirmed or presumed COVID19 - Someone under investigation of COVID19 - Someone who has been asked to quarantine themselves Interview on 3/9/21 with the Qualified Intellectual Disabilities Professional (QIDP) and Habilitation Coordinator (HC) confirmed all visitors into the home should be screened for COVID-19 as indicated on the screening form.	W 340		