CENTERS FOR MEDICARE & M	MEDICAID SERVICES					
				0	<u>MB NO.</u>	0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED 03/09/2021		
	34G318					
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LIFE, INC WILSON STREET GROU	UP HOME			16 WILSON STREET EXTENSION LYMOUTH, NC 27962		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249 PROGRAM IMPLEMEN CFR(s): 483.440(d)(1)			49			
formulated a client's ind each client must receive treatment program cons interventions and servic and frequency to suppo objectives identified in t plan. This STANDARD is no Based on observations interviews, the facility fa clients (#2, #4 and #5) r active treatment progra interventions and servic identified in the Individu the area of meal prepar During observations thr home on 3/8 - 3/9/21, vit food and drink items for were prompted or enco preparation tasks. Interview on 3/9/21 with preparing all of the mea virus and potential cross Additional interview indi management. Review on 3/9/21 of clief	<ul> <li>CFR(s): 483.440(d)(1)</li> <li>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.</li> <li>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:</li> <li>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.</li> <li>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.</li> <li>Review on 3/9/21 of client #2's IPP dated 3/24/20 revealed, "I enjoy helping staff with meals." The</li> </ul>					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 03/10/2021

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MULTIPLE CONSTRUCTION			MB NO. 0938-039 (X3) DATE SURVEY		
		IDENTIFICATION NUMBER:	. ,			COMPLETED	
	34G318		B. WING	03/09/2021			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
LIFE, IN	C WILSON STREET G	ROUP HOME		I116 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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	HOULD BE COMPLETIO		
W 249	noted, "I can assist preparationStaff s encourage me. I a appliances with sta Review o 3/9/21 of indicated, "I need a preparation" Interview on 3/9/21 Disabilities Profess Coordinator (HC) ir COVID-19 cases ir interview confirmed assisting with meal COVID-19 virus an	of client #4's IPP dated 12/8/20 staff in meal still continue to offer and ttempt to use kitchen ff direction." client #5's IPP dated 4/28/20 assistance from staff in meal with the Qualified Intellectual ional (QIDP) and Habilitation ndicated there were no current to the home. Additional d none of the clients are preparation tasks due to the	W 249				
W 340	acknowledged clier some meal prepara the implementation Handwashing). NURSING SERVIC CFR(s): 483.460(c) Nursing services m other members of t appropriate protect measures that inclu training clients and health and hygiene	nts could be assisting with ation tasks individually and with of sanitary practices (i.e. CES )(5)(i) nust include implementing with the interdisciplinary team, ive and preventive health ude, but are not limited to staff as needed in appropriate	W 340				

If continuation sheet Page 2 of 3

		AND HUMAN SERVICES				FORM	03/10/2021 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		34G318	B. WING			03/(	09/2021
NAME OF F	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE, INC	C WILSON STREET G	ROUP HOME			116 WILSON STREET EXTENSION PLYMOUTH, NC 27962		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 340	Continued From pa finding is:	ige 2	W 3	340			
	3/9/21 at 6:15am, s the home. The surv	home on 3/8/21 at 9:50am and staff invited the surveyor into veyor's temperature was not s were presented for					
	COVID-19 visitor so	with Staff A revealed the creening consisted of a and completion of questions 9.					
	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:						
	shortness of breath 2. In the past 14 da any of the following - Someone with c COVID19 - Someone under	ays, have you had contact with					
	Disabilities Professi Coordinator (HC) co	with the Qualified Intellectual ional (QIDP) and Habilitation onfirmed all visitors into the reened for COVID-19 as reening form.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 925415

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