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

PRINTED: 03/17/2021
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
	34G235	A. BUILDING ______ B. WING ______	03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC FOLLY STREET GROUP HOME	65 FOLLY STREET SW SUPPLY, NC 28462

(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
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039	E 039 The facility will ensure that exercises will be conducted annually to test the emergency plan. The QP will conduct and facilitate an annual tabletop activity to address all aspects of the emergency plan. The activity conducted will include a paper-based tabletop exercise to include discussions that are narrated and relevant emergency scenarios, directed messages and questions that are prepared to challenge the emergency plan and discuss any activation concerns with the actual plan. This exercise will include consumers, staff, and managers from all facilities within the region and be relevant to real life scenarios. The QP will encourage the consumers to address the scenarios and to answer questions regarding the emergency plan to ensure consumers are gaining an understanding of the plan. Monitoring will occur at least quarterly during the safety meetings that are held by the local team and bi-annually during the audits that are conducted by members of the QA/QI team.	4-30-2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Director, IID (X6) DATE: 4-2-21

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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E 039	Continued From page 1 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 2 (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]	E 039		

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E 039	Continued From page 3 (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to	E 039		

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E 039	Continued From page 4 test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises	E 039		

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E 039	Continued From page 5 to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise	E 039		

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E 039	Continued From page 6 is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure facility/community-based or tabletop exercises to test their Emergency Preparedness (EP) plan were conducted. This potentially affected clients #1, #2, #3, #4, #5 and #6. The finding is: Review on 3/15/21 of the facility's EP plan dated January 2021, did not include a full-scale community-based or tabletop exercise for 2020. During an interview on 3/15/21, the qualified intellectual disabilities professional (QIDP) revealed the facility did not perform a tabletop exercise for 2020.	E 039		
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	W 249		

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W 249	Continued From page 7 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 4 audit clients (#2, #3 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of self help skills. The finding is: During lunch and dinner observations in the home on 3/15/21, all the staff served the food, passed the food and poured the drinks for clients #2, #3 and #6. At no time were clients #2, #3 and #6 prompted to serve/pass their own food and pour their own drinks. During an interview on 3/15/21, Staff C revealed because of COVID-19 no clients were being allowed to serve, pass or pour during meals. Review on 3/15/21 of clients #3, #3 and #6 skill assessments revealed all three are totally independent in the following, "pours, serves self from bowl/platter, serves self appropriate portions, passes bowl/platter and asks that bowl/platter be passed." During an interview on 3/15/21, the qualified intellectual disabilities professional (QIDP) stated, clients #2, #3 and #6 should have been given the opportunity to serve, pass and pour during meals. Further interview revealed during the being of COVID-19 staff were doing all the passing,	W 249	W 249 Facility will ensure that each consumer receives continuous active treatment to include the needed interventions to support the achievement of the specific objectives, independence in relation to strengths, and assistance in regards to needs as outlined in their IPP. This will include that consumers will participate in meal preparation to the level of their ability. The strengths and needs of each client will be reviewed as outlined in their skills assessment that is completed annually. Any changes agreed upon by the team after review of these assessments, will be added to each person's IPP in the form of an addendum to the current plan. These findings will be shared with all staff members as they will receive updated in-service specific to the needs of each client, including but not limited dining skills. This will include specific strengths and needs and assurance of active treatment over all aspects of daily living. All staff will receive updated in service specific to the needs of the consumer. In-service will be facilitated by the Habilitation Coordinator, and monitoring will occur no less than 4 times monthly as part of their inspections including meal observations. This will occur in the home and at the workshop settings. This will help to ensure all IPPs are implemented/followed to include such strengths and needs as specified.	4-30-2021

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W 249	Continued From page 8 pouring and serving; but are no longer doing it.	W 249		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #6's written informed consents were obtained from both co-guardians. This affected 1 of 4 audit clients. The finding is: Review on 3/15/21 of client #6's record revealed guardianship paperwork identifying co-guardians. Further review of client #6's record revealed all consents were signed by one guardian. Further review revealed client #6 has a behavior support plan (BSP) which includes the medications for Ativan and Elavil. During an interview on 3/15/21, the qualified intellectual disabilities professional (QIDP) confirmed only one of client #6's co-guardians had signed her consents, including her BSP consents.	W 263	W 263 The facility will ensure that programs are conducted only with the written informed consent of the consumers, parents (if consumer is a minor) or legal guardian. The facility will ensure that all correspondence and consents, including but not limited to behavior plans are obtained and signed by both guardians when it is determined that an individual is determined to be served by co-guardians. All consents and documents will be reviewed and corrected as deemed necessary. Once received, the QP will keep both consents and correspondences on file and in Therap. Monitoring will occur monthly by the QP during scheduled QP checklist inspections completed, as well as annually and semiannually when consents are completed for each individual.	4-30-2021
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.	W 340		

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W 340	Continued From page 9 This STANDARD is not met as evidenced by: Based on observations, record review and interview, the nursing services failed to ensure that staff were sufficiently trained in taking the temperature in regards to COVID-19 protocol. This potentially effected all clients residing in the home (#1, #2, #3, #4, #4 and #6).. The finding is: During morning observations in the home on 3/15/21 at 8:57am, the surveyor entered the home. Further observations revealed Staff B who opened the door asked the surveyor to spray the bottom of her shoes, with a bottle of disinfectant which was outside on the porch. Further observations revealed Staff B sitting on a chair right within view of the surveyor. At no time did either Staff A or Staff B ask the surveyor if they took their temperature or what their temperature was. Additional observations revealed there was a sign on the which stated: "STOP sanitize hands Check your temperature." Further observations revealed there was no sign or directions about where to locate a thermometer to check your temperature before entering the house. During and interview on 3/15/21, Staff C stated that everyone temperature is taken before they enter the home. Further interview revealed all staff have been trained to ensure people entering the home take their temperature. During an interview on 3/15/21, the qualified intellectual disabilities professional (QIDP) stated the surveyor should have known where the thermometer was to take their own temperature. Further interview revealed the thermometer was	W 340	W 340 Facility will ensure that nursing services will include the implementation of appropriate protective and preventive health measures are in place to train clients and staff as needed in appropriate health and hygiene. The nurse will ensure that staff are re in-serviced on the appropriate COVID-19 protocol for anyone entering the home to include questionnaire, temperature check and proper cleansing. The nurse will post all instructions of what needs to occur for anyone who is entering the home. The instructions will be posted outside the entrance door. Staff will be in serviced to ask any non-essential worker who enters the home if they have followed the guidelines. Guidance will also be offered to staff to anyone denying admission into the home and when to notify management regarding a visitor's symptoms. A log will be kept at the entrance of anyone entering the home to log visitors (workers or visitors) and to track the recorded data of each person. Monitoring will take place any time the nursing or management visits the facility to ensure compliance with the protocol but not less than twice weekly.	4-30-2021

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W 340	Continued From page 10 located inside of a drawer located outside on the porch.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure all medications were administered in accordance with physician's orders. This affected 2 of 4 audit clients (#2 and #4) observed receiving medications. The findings are: A. During medication administration in the home on 3/15/21 at 6:32pm, client #4 consumed Lamotrigine 100mg with four other pills. Review on 3/16/21 of client #4's physician orders indicated, "Lamotrigine 100mg Take one tablet by mouth in the evening 8pm." B. During medication administration in the home on 3/16/21 at 7:45am, client #2 consumed his medications, including Janumet. Further observations revealed client #2 was finishing his breakfast at 7:15am. Review on 3/16/21 of client #2's physician orders indicated, "Janumet Take one tablet by mouth twice daily with meals." During an interview on 3/16/21, the management staff confirmed clients #4 and #2 physician orders	W 368	W 368 The facility will ensure that all drugs are administered in accordance with a physician's order. The facility nurse will review all medical orders to ensure that all drugs have clear and accurate instructions in regard to administrations. Following review, all staff will receive an in-service staff on the correct time to administer them as well clarification of all orders that indicate "take with meals". Any changes that are needed in the Therap system will be made as well as rescheduled for the times for the medication to be taken as close to mealtime as possible so as to not take the medication on an empty stomach per med orders. Monitoring will occur at least weekly during scheduled observations in the home by facility managers as a part of their monthly CRT inspections including med observations. This will help to ensure all med orders are implemented/followed. This information will be documented in the FID app system used by LIFE, Inc to record observations.	4-30-2021

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W 368	Continued From page 11 were not followed as ordered.	W 368		
W 383	DRUG STORAGE AND RECORDKEEPING CFR(s): 483.460(l)(2) Only authorized persons may have access to the keys to the drug storage area. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure only authorized persons have access to keys to the drug storage area. The finding is: During afternoon observations in the home on 3/15/21 at 12 noon, Staff A reached behind the refrigerator and took out an unlocked black box and removed a key. Further observations revealed Staff A then walked to the medication room door and unlocked it with the key. Staff A went into the medication room and took out a box of gloves; Staff A then returned the key back to the unlocked black box and replaced it back behind the refrigerator. During an interview on 3/16/21, management staff confirmed the medication key was accessible to anyone in the home.	W 383	W 383 The facility will ensure that only authorized persons have access to keys to the drug storage area. All keys will be secured. The Habilitation Coordinator, Nurse, and QP will designate a specific area to store the keys that only authorized personnel will be able to access. Monitoring to ensure key is not accessible will occur no less than 4 times monthly by facility managers as a part of their monthly CRT inspections including med observations.	4-30-2021
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills under varied conditions. This STANDARD is not met as evidenced by: Based on review of fire drill reports and interview, the facility failed to ensure fire evacuation drills	W 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G235	A. BUILDING ______ B. WING ______	03/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC FOLLY STREET GROUP HOME	65 FOLLY STREET SW SUPPLY, NC 28462

(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 441	Continued From page 12 were conducted at varied times. This affected all clients (#1, #2, #3, #4, #5 and #6). The finding is: Review of fire drill reports on 3/15/21 revealed the following: Five fire drills were conducted on first shift: 2pm; 1:49pm; 1:41pm; 1:29pm; and 2:40pm. During an interview on 3/15/21, the qualified intellectual disabilities professional (QIDP) revealed first shift hours are 7am - 3pm and 7:30am - 3:30pm. The QIDP confirmed the fire drills on first shift were not varied.	W 441	W 441 The facility will ensure that all fire drills will have varied times on each shift. The facility will ensure that all fire drills will not be at the same or close to the same times. A schedule will be developed to prevent the occurrence. Fire drills will be done in accordance with Life policy and will have fluctuating times per shift. Persons responsible for drills will receive training as to the fluctuating schedule. Monitoring will occur at least monthly during the safety inspections of the home and quarterly during the safety meetings that are held by the local team and bi-annually during the audits that are conducted by members of the QA/QI team.	4-30-2021

April 2, 2021

Eugina Barnes, BSW, QMRP
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. / Folly Street Group Home

Dear Ms. Barnes:

Enclosed please find our written plan of correction for the recent survey at our Folly 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,

Susan Ayers
Director of ICF/IID Services

art
Enclosure

2609 Royall Avenue
Goldsboro, North Carolina 27534
Phone: (919) 778-1900 Fax: (919) 778-1911

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