STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G091	A. BUILDING _____ B. WING _____	05/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC LAVENHAM GROUP HOME	3700 LAVENHAM ROAD NEW BERN, NC 28560

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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 5 audit clients (#1) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of adaptive devices and mealtime assistance guidelines. The findings are: A. During observations in the home on 5/18/21 from 11:58am to 12:50pm, client #1 was observed eating lunch. Client #1's plate and fork were on the table in front of him, and a cup of juice and a cup of water were sitting on the table behind his plate. Client #1 was observed to feel around on the table for his fork. Once he located his fork, he was observed to use his fork to scoop his food. At 12:50pm, Staff A was observed to tell client #1, "Drink your juice." During the 52 minutes of observation, client #1 did not drink any of his beverage. However, he was observed to cough 10 times. Additional observations in the home on 5/19/21 from 8:03am to 8:37am, client #1 was observed	W 249		

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

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W 249	Continued From page 1	W 249		

eating breakfast. Client #1's plate and fork were on the table in front of him, and a cup of milk and a cup of water were sitting on the table behind his plate. Client #1 was observed to feel around on the table for his fork. Once he located his fork, he proceeded to eat his breakfast. During the 34 minutes of observation, client #1 did not drink any of his beverage until Staff A gave him a Boost supplement at 8:37am. In addition, client #1 was observed to cough 9 times.

Review on 5/18/21 of client #1's IPP dated 8/7/20 revealed client #1 has a diagnosis of significant vision loss, with a history of cataract surgery in both eyes.

Review on 5/18/21 of client #1's mealtime assistance guidelines (undated) posted in the dining room of the home revealed staff are to provide sighted assistance as needed for client #1 to spear his food with his fork and to encourage client #1 to take a sip of his beverage after every 3-4 bites of food. In addition, the mealtime assistance guidelines revealed client #1 is at risk for aspiration.

Interview on 5/19/21 with the Qualified Intellectual Disabilities Professional (QIDP) II, QIDP I, Habilitation Coordinator and Nurse confirmed the mealtime assistance guidelines are current, and staff should be following these guidelines by providing sighted assistance with spearing his food with his fork as needed, and encouraging client #1 to drink a sip of his beverage after every 3-4 bites of food.

B. During observations in the home on 5/18/21 and 5/19/21, client #1 was observed to wear a gait belt. Throughout the observations, staff were

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W 249	Continued From page 2 observed to assist client #1 with ambulating around his home, going from the living room to the bathroom or living room to the dining room by either holding his hand or holding him under his arm, and at times staff were observed to walk backwards in front of client #1 and hold both his hands. At times, one staff would assist client #1 and at other times, two staff would assist. Review on 5/18/21 of client #1's IPP dated 8/7/20 revealed client #1 is ambulatory and is supported with the use of a gait belt. Review on 5/19/21 of client #1 Physical Therapy (PT) evaluation dated 3/23/16 revealed, "two habilitation staff to provide assistance and the use of a gait/transfer belt." Interview on 5/19/21 with the QIDP II, QIDP I and Habilitation Coordinator revealed that client #1 can be supported at times with one staff and other times may require two staff, depending on his day. It was revealed he has had a decrease in his ambulation skills with the onset of Dementia. The QIDP II confirmed that staff should be utilizing the gait belt by standing to his side, hand on the gait belt, to assist client #1 with ambulating.	W 249		
W 268	CONDUCT TOWARD CLIENT CFR(s): 483.450(a)(1)(i) These policies and procedures must promote the growth, development and independence of the client. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility	W 268		

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W 268	Continued From page 3 failed to ensure that positive interactions were provided for 5 of 5 audit client (#1, #2, #3, #4 and #5). The finding is: During observations in the home on 5/18/21 from 10:30am through 1:00pm, Staff A and Staff B were observed to talk to the client's in a harsh tone of voice. For example, Staff A was observed to tell client #2 to "just get something to play with" very harshly, and when client #2 looked at her, Staff A said in a sharp tone, "Yeah, you!" At 12:16pm, Staff A was observed to tell client #1 to wipe his mouth. Client #1 sat there and Staff A told him, "Oh come on, its right in front of you" in a harsh tone. At approximately 12:18pm, Staff B was assisting client #4 with making his plate for lunch. Client #4 was looking around, and Staff B told client #4, "Just pay attention to what you're doing" in a harsh tone of voice. At this time, the Qualified Intellectual Disabilities Professional (QIDP) I told staff to watch their tones of voice when speaking to the clients. Additional observations in the home on 5/19/21 from 6:30am through 9:00am, Staff A and Staff B were observed to talk to the clients in a harsh tone of voice, or point at the client and wave their hand, motioning for them to move out of the way without saying anything. Review on 5/19/21 of the facility's "Consumer Rights Policy" revealed, "Be treated with consideration, respect and full recognition of his dignity and individuality." Interview on 5/19/21 with the QIDP II, QIDP I and Habilitation Coordinator confirmed staff should speak to the clients in a positive manner and not with harsh tones of voice.	W 268		

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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 observation, record review and interview, the facility failed to ensure client #5's medications were administered in accordance with physician's orders. This affected 1 of 5 audit clients. The finding is: During observations of medication administration in the home on 5/19/21 at 7:00am, Staff A and client #5 were observed to punch two Vitamin D3 2000 unit capsules, one Metoprolol Succ ER 25mg tablet, one Lisinopril 40mg tablet, one Hydrochlorthiazide 12.5 capsule, and one Docusate 100mg Soft Gel into a medication cup. The medications were then transferred to a small plastic bag and Staff A was observed to crush the pills and capsules before mixing them into apple sauce. Review on 5/19/21 of client #5's Physician's Orders dated 4/30/21 revealed an order for Metoprolol Succ ER 25mg, "Take one tablet by mouth every day. Do not crush," and an order for Docusate 100mg Soft Gel, "Take 1 capsule by mouth every day. Do not crush." Interview on 5/19/21 with the facility's Nurse confirmed that client #5's medication should have been administered in accordance with the physician's orders, and the Metoprolol Succ ER 25mg tablet and Docusate 100mg Soft Gel should not have been crushed.	W 368		

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W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure specially-prescribed diets for 4 of 5 audit clients (#1, #2, #3 and #5) were followed as indicated. The findings are: A. During observations in the home on 5/18/21 at 5:38pm, client #1 was observed eating dinner. On client #1's plate was green beans, corn and chicken. Client #1's chicken was pulled off of the bone by staff and pulled apart into pieces. Client #1's green beans and chicken were larger than 1/4 inch in size. Additional observations in the home on 5/19/21 at 8:03am, client #1 was observed eating breakfast. Staff B was observed to put a piece of cheese toast into a chopper and modify it into a ground consistency. The toast was placed on client #1's plate and he consumed it. At no time was the cheese toast moistened. Review on 5/18/21 of client #1's Individual Program Plan (IPP) dated 8/7/20 revealed a regular diet, finely chopped into 1/2 inch pieces and "dry foods should be moistened as needed with broth, gray, etc." Interview on 5/19/21 with the Qualified Intellectual Disabilities Professional (QIDP) II, QIDP I and Habilitation Coordinator confirmed client #1's	W 460		

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W 460	Continued From page 6 chicken and green beans should have been finely chopped to a 1/4 inch size, and his toast should have been moistened as indicated by his diet order. B. During observations in the home on 5/18/21 at 12:05pm, client #3 was observed eating a hotdog. The hotdog had been cut into approximately 5 pieces with the meat still in the bun in each piece. Additional observations in the home on 5/18/21 at 5:43pm revealed client #3 eating dinner, which included a chicken leg and thigh that staff had pulled off the bone and pulled apart into pieces, and a biscuit that was cut into 5 pieces. The chicken had large pieces mixed in it, and the pieces of biscuit were larger than 3/4 - 1 inch in size. Review on 5/19/21 of client #3's IPP dated 9/19/20 revealed a diet order which consists of meats and other appropriate foods cut into 3/4 - 1 inch bite size pieces and sandwiches cut into 16 pieces, be sure pieces are completely separated. Interview on 5/19/21 with the QIDP II, QIDP I and Habilitation Coordinator confirmed that client #3's hotdog should have been serrated into smaller pieces, and that his chicken and biscuit should have been cut into 3/4 - 1 inch pieces as indicated by his diet order. C. During observations in the home on 5/19/21 at 5:46pm, client #2 was observed eating dinner. Client #2's dinner include a chicken leg and thigh which had been pulled off the bone by staff and pulled apart into pieces. The pieces of chicken were larger than 3/4 - 1 inch in size.	W 460		

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W 460	Continued From page 7 Review on 5/18/21 of client #2's IPP dated 7/1/20 revealed a diet order to cut foods into 3/4 - 1 inch bite size pieces. Interview on 5/19/21 with the QIDP II, QIDP I and Habilitation Coordinator confirmed that client #2's chicken should have been cut into 3/4 - 1 inch pieces as indicated by her diet order. D. During observations in the home on 5/18/21 at 12:02pm, client #5 was observed eating a hotdog. The hotdog had been cut into approximately 5 pieces with the meat still in the bun in each piece. Additional observations in the home on 5/18/21 at 5:48pm revealed client #5 eating dinner, which included a chicken leg and thigh that staff had pulled off the bone and pulled apart into pieces, and a biscuit that was cut into 4 pieces. The chicken had large pieces mixed in it, and the pieces of biscuit were larger than 3/4 - 1 inch in size. Review on 5/18/21 of client #5's IPP dated 8/7/20 revealed a diet order that includes meats and other appropriate foods cut into 3/4 - 1 inch bite size pieces and sandwiches cut into 16 pieces, be sure pieces are completely separated. Interview on 5/19/21 with the QIDP II, QIDP I and Habilitation Coordinator confirmed that client #5's hotdog should have been serrated into smaller pieces, and that her chicken and biscuit should have been cut into 3/4 - 1 inch pieces as indicated by her diet order.	W 460		