

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

PRINTED: 06/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC. WALNUT STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 EAST WALNUT STREET GOLDSBORO, NC 27530		
(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	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 2 of 3 audit clients (#3 and #5) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of cooking. The finding is:</p> <p>During meal preparation observations in the home on 6/14/21 from 5:10pm - 6:18pm, clients were not consistently or actively prompted or encouraged to assist with cooking tasks. At 5:18pm, client #5 was prompted to place hamburger meat into a pan and place plates and cups on the table. At 5:28pm, client #5 left the kitchen while client #3 remained. As client #3 periodically stood or wandered around in the kitchen unengaged, Staff C completed tasks such as cooking hamburger meat, pasta, and green beans, cutting vegetables (lettuce, tomatoes and cucumbers), preparing salad in a bowl, preparing spaghetti with sauce and meat on the stove, using a chopper to grind up hamburger meat, preparing pitchers of tea, coffee and ice, filling individual cups with salad dressing and placing</p>	W 249			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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: 06/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC. WALNUT STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 EAST WALNUT STREET GOLDSBORO, NC 27530		
(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	<p>Continued From page 1</p> <p>food items in serving bowls. Client #3 was not prompted or assisted to complete any cooking tasks while in the kitchen and no other clients in the home were prompted to participate in cooking tasks.</p> <p>Interview on 6/14/21 with Staff C revealed client #5 and client #6 are the only clients in the home who assist with cooking tasks. Additional interview indicated client #3 was only in the kitchen so she could be monitored by the staff so she won't try to "get into everything". The staff stated, "She likes being in here (the kitchen)."</p> <p>Review on 6/15/21 of client #3's Adaptive Behavior Inventory (ABI) dated 12/16/20 noted she has various needs in the area of meal preparation. The ABI also indicated the client has partial independence with using the microwave, oven and stove top, identifying vegetables, dairy products, meats, breads, cereals and kitchen equipment.</p> <p>Review on 6/15/21 of client #5's IPP dated 10/20/20 revealed, "I need some assistance with cutting my food...I can assist in the kitchen." The plan indicated the client has a "vast number of skills" in the domestic/home living area and requires reminders and prompts from staff to do a thorough job in completing a task. Additional review of the client's ABI dated 1/25/21 indicated she has numerous strengths in the area of meal preparation and has partial independence with using the microwave, oven and stove top, identifying foods and kitchen equipment, preparing frozen, canned and fresh foods, meat dishes, combination dishes, and baking, preparing beverages, breakfast, lunch and dinner meals and using a manual and electric can</p>	W 249			

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

PRINTED: 06/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC. WALNUT STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 EAST WALNUT STREET GOLDSBORO, NC 27530		
(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	Continued From page 2 opener, mixer, blender and toaster.	W 249			
W 253	<p>Interview on 6/15/21 with the Qualified Intellectual Disabilities Professional (QIDP) and QIDP II confirmed client #5 has various skills in the kitchen; however, client #3 needs more physical or hand-over-hand assistance to complete tasks in the kitchen.</p> <p>PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2)</p> <p>The facility must document significant events that are related to the client's individual program plan and assessments.</p> <p>This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a rights restriction used to address another client's behaviors was documented in the individual program plan (IPP). This affected 5 of 6 clients residing in the home (#1, #2, #4, #5 and #6). The findings are:</p> <p>A. During observations in the home throughout the survey on 6/14 - 6/15/21, the doorway leading into the kitchen contained an alarm/chime. The alarm sounded loudly throughout the home each time anyone entered/exited through the doorway. All of the clients residing in the home were observed to enter/exit the kitchen utilizing this doorway.</p> <p>Interview on 6/14/21 with Staff C revealed the door alarm was in place due to client #3's behaviors. Additional interview indicated the client will attempt to go into the kitchen and "eat</p>	W 253			

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

PRINTED: 06/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC. WALNUT STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 EAST WALNUT STREET GOLDSBORO, NC 27530		
(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 253	<p>Continued From page 3</p> <p>everything". The staff noted her bedroom also has an alarm to monitor at night and the kitchen door knob has a locking cover to keep her from opening it.</p> <p>Review on 6/15/21 of client #3's Individual Program Plan (IPP) dated 12/9/20 revealed, "I also go into the kitchen and take food that does not belong to me."</p> <p>Review on 6/14 - 6/15/21 of each client's record (#1, #2, #4, #5 and #6) did not include any information regarding an alarm/chime being utilized in the home to address another client's behavior which also detected their movement in/out of the kitchen area.</p> <p>Interview on 6/15/21 with the Qualified Intellectual Disabilities Professional (QIDP) and QIDP II confirmed the alarm/chime was positioned over the doorway leading into the kitchen to help staff detect when client #3 entered the area due to her inappropriate behaviors around food. The QIDP II confirmed the alarm's use was not included in any other client's IPP.</p> <p>B. During observations in the home throughout the survey on 6/14 - 6/15/21, client #2 and client #3 were noted to share a bedroom in the home. Closer observation of the doorway leading into clients' bedroom revealed an alarm/chime. The alarm sounded loudly throughout the home each time the two clients entered/exited through the doorway.</p> <p>Interview on 6/14/21 with Staff C revealed the door alarm was in place at client #3's doorway due to her inappropriate behaviors at night.</p>	W 253			

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

PRINTED: 06/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC. WALNUT STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 EAST WALNUT STREET GOLDSBORO, NC 27530		
(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 253	Continued From page 4 Review on 6/15/21 of client #3's Individual Program Plan (IPP) dated 12/9/20 revealed, "There is a chime placed above my bedroom door to alert staff when I enter/exit the room..." Review on 6/15/21 of client #2's IPP dated 2/18/21 did not include any information regarding an alarm/chime being utilized over her bedroom door to address client #3's behavior which also detected her movement in/out of her own bedroom. Interview on 6/15/21 with the QIDP I and QIDP II confirmed the alarm was installed over client #2's and client #3's bedroom door to address client #3's inappropriate behaviors. The QIDP II also confirmed the alarm's use was not included in client #2's IPP as it also detected her movement in/out of her own bedroom.	W 253			
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a technique to manage client #3's inappropriate behaviors was included in a formal active treatment plan. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 6/14 - 6/15/21, the doorway leading into the kitchen contained an alarm/chime. The alarm	W 288			

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

PRINTED: 06/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC. WALNUT STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 EAST WALNUT STREET GOLDSBORO, NC 27530		
(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 288	Continued From page 5 sounded loudly throughout the home each time anyone entered/exited through the doorway. All of the clients residing in the home were observed to enter/exit the kitchen utilizing this doorway. Interview on 6/14/21 with Staff C revealed the door alarm was in place due to client #3's behaviors. Additional interview indicated the client will attempt to go into the kitchen and "eat everything". Review on 6/15/21 of client #3's Behavior Intervention Plan (BIP) dated 12/2/19 revealed an objective to reduce the frequency of defined behavior episodes to 15 or less per month for 8 consecutive months. The plan addressed defiance, stealing, aggression/agitation and PICA behaviors. Additional review of the BIP noted, under Proactive Intervention Techniques, "...Door alarms are installed over [Client #3's] bedroom door and above the med room door to alert staff when she is leaving or entering the rooms..." Further review of the BIP did not include the use of an alarm/chime over the kitchen doorway in the home to address client #3's behaviors. Interview on 6/15/21 with the Qualified Intellectual Disabilities Professional (QIDP) and QIDP II confirmed the door alarm had been placed over the kitchen door to address client #3's inappropriate behaviors.	W 288			
W 312	DRUG USAGE CFR(s): 483.450(e)(2) Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual	W 312			

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

PRINTED: 06/16/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G034	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/15/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC. WALNUT STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1011 EAST WALNUT STREET GOLDSBORO, NC 27530		
(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 312	<p>Continued From page 6</p> <p>elimination of the behaviors for which the drugs are employed.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure drugs to manage client behavior were only used as an integral part of the client's Individual Program Plan (IPP). This affected 1 of 4 audit clients (#2). The finding is:</p> <p>Review on 6/15/21 of client #2's Medication Administration Record (MAR) for June 2021 revealed the client ingests Duloxetine (Cymbalta) 30 mg. Additional review of the client's Behavior Intervention Plan (BIP) dated 10/20/20 revealed an objective to reduce the frequency of defined oppositional behavior episodes to 3 or less per month for 8 consecutive months. Further review of the plan did not identify the use of Cymbalta to address behaviors.</p> <p>Interview on 6/15/21 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 receives Cymbalta to address behavioral issues and the medication should be included in her BIP.</p>	W 312			