

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

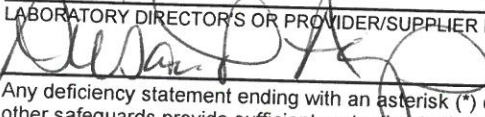
PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870
---	--

(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 189	<p>STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure all staff were sufficiently trained in the facility's process for medication administration. The finding is:</p> <p>During observations in the home of medication administration on 5/10/21 at 4:17pm, Staff D was administering client #2 her medications. Prior to medication administration, client #2 was having an episode of nausea and vomiting. After administering her 4:00pm medications, Staff D was observed to put one Ondansetron ODT 4mg tablet, used PRN for nausea and vomiting, into a full container of yogurt. Staff D attempted to spoon feed the yogurt to client #2. Client #2 refused to take the yogurt. At 4:31pm, Staff D was observed to throw the container of yogurt in the trash can.</p> <p>Interview on 5/11/21 with Staff B revealed when a pill falls on the floor or if a client refuses a medication that has been mixed into yogurt, applesauce, etc., staff should flush the pill down the toilet and notify the nurse, unless the pill is a narcotic. If the pill is classified as a narcotic, staff should secure the pill in the narcotics box, double lock it and notify the nurse.</p> <p>Interview on 5/11/21 with the facility Nurse revealed the facility does not have a policy that</p>	W 189	<p>W 189</p> <p>The facility will ensure that all employees receive initial and ongoing training on the medication administration process. The facility will determine a procedure for medication disposal that has been mixed with other substances. Staff will be in-serviced to ensure they are all aware of how all medications are to be properly disposed. This plan of correction will be monitored by the QP I, Hab Coordinator, and Nurse on an ongoing basis through scheduled inspections to include medication monitoring a minimum of 3 times a month. This documentation will take place in the FIDS app in the monthly random inspections.</p> <p style="text-align: right;">DHSR - Mental Health JUN 07 2021 Lic. & Cert. Section</p>	7-5-2021
-------	---	-------	--	----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Director ICF/117	(X6) DATE 6/4/21
---	----------------------------------	----------------------------

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.

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

PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870
---	--

(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 189	Continued From page 1 provides information on what to do when a client refuses medication that has been mixed into yogurt, applesauce, etc., but this is part of the medication administration training and testing done annually with staff. The facility Nurse confirmed the yogurt with the Ondansetron ODT 4mg tablet should not have been thrown in the trash, but should have been flushed down the toilet and the Nurse should have been notified.	W 189		
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 3 of 6 audit clients (#1, #2 and #4) 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 equipment and devices. The findings are: A. During observations in the home on 5/10/21 through 5/11/21, client #2 was observed to wear socks, but no shoes. Throughout the observations, client #2 was observed to ambulate around her home or stand in various locations in	W 249	W 249 The facility will ensure that all consumers receive continuous active treatment to support their individual program plans. All client needs in regards to adaptive equipment will be reviewed. Each staff will be in-serviced to ensure they follow all recommendations being made by Therapist. Specifically, the QPI will implement a training objective to increase tolerance to wear the built-up shoe and will monitor and ensure that all adaptive equipment is being utilized as recommended for OT and PT services. Any adaptive equipment necessary will be used over all aspects of daily living as appropriate. This plan of correction will be monitored by the QP, Hab Coordinator and Nurse as part of the LIFE, Inc. QA/QI process and documented in the FIDs app of random inspections a minimum of 3 times a month.	7-5-2021

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

PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870
---	--

(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 2</p> <p>the home. At no time during the observations was client #2 prompted to wear shoes.</p> <p>Review on 5/10/21 of client #2's IPP dated 12/7/20 revealed client #5 wears a built-up left shoe to stabilize standing and ambulating.</p> <p>Interview on 5/11/21 with Staff G revealed client #5 does wear a built up left shoe. Staff G revealed that staff put the shoe on client #2 when she is getting dressed in the morning, but client #2 kicks the shoe off. Staff G revealed when this happens, staff should prompt client #2 to wear the shoes throughout the day.</p> <p>Interview on 5/11/21 with the Qualified Intellectual Disabilities Professional (QIDP) and Habilitation Coordinator (HC) revealed there is no set schedule for when client #2 wears the build up shoe. The QIDP and HC confirmed that staff should prompt her to wear the shoe when ambulating or standing as the IPP indicates.</p> <p>B. During observations in the home on 5/10/21 at lunch, afternoon snack and dinner, and additional observations of breakfast on 5/11/21, client #2 was observed to eat with a built-up handled, curved spoon. During observations of medication administration on 5/10/21 and 5/11/21, client #2 was given her medications in a container of yogurt. Client #2 was provided a white, plastic spoon to eat the yogurt with.</p> <p>Review on 5/10/21 of client #2's IPP dated 12/7/20 revealed client #2 uses adaptive equipment when eating that includes a small, built-up handled, curved spoon.</p> <p>Interview on 5/11/21 with the QIDP and HC</p>	W 249		
-------	--	-------	--	--

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

PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870		
(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 3</p> <p>revealed client #2 should have used her adaptive spoon to take her medication with in the yogurt.</p> <p>Interview on 5/11/21 with the facility Nurse confirmed client #2 should have used her adaptive spoon during medication administration if she is taking her medication with food.</p> <p>C. During observations in the home on 5/10/21 at 3:15pm, client #4 was observed eating snack. Client #4 was eating yogurt and strawberries, served in a regular serving bowl.</p> <p>Review on 5/10/21 of client #4's IPP dated 11/3/20 revealed client #4 uses adaptive dining equipment which includes a scoop bowl.</p> <p>Interview on 5/11/21 with the QIDP and HC confirmed client #4's yogurt and strawberries should have been served in her adaptive scoop bowl and not a regular serving bowl.</p> <p>D. During observations in the home on 5/10/21 at 3:32pm, Staff C was observed to put a regular serving bowl of strawberries and yogurt on the table for client #1. Client #1 was observed to eat her snack from the bowl.</p> <p>Review on 5/10/21 of client #1's IPP dated 6/4/20 revealed client #1 uses adaptive dining equipment which includes a scoop bowl.</p> <p>Interview on 5/11/21 with the QIDP and HC confirmed client #1's yogurt and strawberries should have been served in her adaptive scoop bowl and not a regular serving bowl.</p>	W 249			
W 454	<p>INFECTION CONTROL</p> <p>CFR(s): 483.470(l)(1)</p>	W 454			

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

PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870		
(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 454	Continued From page 4 The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5 and #6). The findings are: A. During observations in the home on 5/10/21 from 4:40pm through 5:40pm, Staff C was observed to prepare the evening meal. Throughout the observations, Staff C would prepare food, touch various surfaces in the kitchen, go to the living room and play a fishing game with three of the clients, return to the kitchen to prepare the food (for example, slicing tomatoes, flipping hamburgers), return back to the living room to play the fishing game, etc. During the observations, Staff C did not wash or sanitize her hands. Interview on 5/11/21 with the Qualified Intellectual Disabilities Professional (QIDP) and Habilitation Coordinator (HC) revealed Staff C should have washed her hands when transitioning from one activity to another. B. During observations in the home on 5/10/21 at 12:15pm, client #5 was observed eating lunch. Several staff were standing in the dining room during this time. Several pieces of fruit from a fruit cup were on the floor beneath client #5's feet. Client #5 was observed to bend down in her chair, pick some of the fruit up off the floor and eat it. Client #5 was then observed to bend back	W 454	W 454 The facility will ensure that all employees receive training to ensure a sanitary environment. Staff will be in-serviced to ensure all sanitary protocols are being followed throughout the day. This includes, but not limited to ensuring that the floor is free of food debris and staff and consumers are washing their hands consistently to prevent cross contamination. This plan of correction will be monitored by the QP/HC/Nurse on an ongoing basis through scheduled inspections a minimum of 3 times a month and documented in the FIDs app of random inspections.	7-5-2021	

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

PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870		
(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 454	Continued From page 5 down, pick more pieces of fruit up, looked around the dining room and shrug her shoulders, and eat the fruit.	W 454			
W 460	Interview on 5/11/21 with the QIDP and HC confirmed that staff should have redirected client #5 from eating the food off the floor. 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 3 of 6 audit clients (#1, #2 and #3) were followed as indicated. The findings are: A. During observations in the home on 5/10/21 at 5:41pm, client #1 was observed to eat dinner. Client #1's meal consisted of a hamburger, french fries and a brownie for desert. Client #1's french fries and brownie were served whole. Additional observations in the home on 5/11/21 at 7:26am revealed client #1 eating breakfast, which included a waffle. Client #1's waffle was cut into several large pieces. Review on 5/10/21 of client #1's Individual Program Plan (IPP) dated 6/4/20 revealed client #1's diet as regular, finely chopped into 1/4" pieces.	W 460	W 460 The facility will ensure that each consumer receives continuous active treatment to support their Individual Program Plan. All diet orders will be reviewed in regards to consistency as recommended by team members and therapist. All staff will be in-serviced on each individuals IPP to include, but not limited to diet order and diet consistency. The QP/HC/Nurse will monitor utilizing monthly inspection forms that will consist of meal observations. Random observations will be made at the facility, day program and community. These observations will be documented in the FIDs random inspection app no less than 3 times per month.	7-5-2021	

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

PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870		
(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 460	<p>Continued From page 6</p> <p>Review on 5/11/21 of client #1's diet order posted in the kitchen of the facility revealed, "...finely chopped into 1/4" pieces or smaller."</p> <p>Interview on 5/11/21 with the Qualified Intellectual Disabilities Professional (QIDP) and Habilitation Coordinator (HC) confirmed client #1's french fries, brownie and waffle should have been finely chopped to 1/4" pieces or smaller as her diet indicates.</p> <p>B. During observations in the home on 5/10/21 at 5:41pm, client #3 was observed eating her dinner, which consisted of a hamburger, french fries and a brownie for desert. Client #3's french fries and brownie were served whole.</p> <p>Additional observations in the home on 5/11/21 at 7:26am revealed client #3 eating breakfast, which included a waffle. Client #3's waffle was cut into several large pieces.</p> <p>Review on 5/11/21 of client #3's IPP dated 12/3/20 revealed client #3's diet as regular, all foods chopped.</p> <p>Review on 5/11/21 of client #3's diet order posted in the kitchen of the facility revealed, "...all foods cut into bite sized pieces, 1" or smaller."</p> <p>Interview on 5/11/21 with the QIDP and HC confirmed client #3's french fries, brownie and waffle should have been cut to 1" or smaller pieces as her diet indicates.</p> <p>C. During observations in the home on 5/10/21 at 5:47pm, client #2 was observed eating her dinner, which consisted of a hamburger, french fries and a brownie for desert. Client 2's french</p>	W 460			

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

PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/11/2021
NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870		
(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 460	<p>Continued From page 7</p> <p>fries and brownie were served whole. Staff D was observed to cut client #2's brownie into 2-3 large pieces.</p> <p>Additional observations in the home on 5/11/21 at 7:44am revealed client #3 eating breakfast, which included a waffle. Client #3's waffle was cut into several large pieces.</p> <p>Review on 5/10/21 of client #2's IPP dated 12/7/20 client #2's diet as regular, all foods cut into small 3/4 - 1" pieces.</p> <p>Review on 5/11/21 of client #2's diet order posted in the kitchen of the facility revealed, "...all foods cut into 3/4 - 1" pieces."</p> <p>Interview on 5/11/21 with the QIDP and HC confirmed client #2's french fries, brownie and waffle should have been cut into 3/4 - 1" pieces as her diet indicates.</p> <p>D. During observations in the home on 5/11/21, client #1 was observed eating breakfast. Client #2 had two cups with straws, one filled with tea and one filled with water.</p> <p>Review on 5/10/21 of client #1's IPP dated 6/4/20 revealed client #1's diet includes 4 ounces of low fat milk daily with breakfast.</p> <p>Review on 5/11/21 of a memo dated 10/15/20 from the facility Nurse posted in the kitchen of the facility revealed, "Client #1 should receive 4 ounces of milk every morning with breakfast."</p> <p>Interview on 5/11/21 with Staff A revealed client #1 was given tea and water for breakfast, and was not provided a choice of milk.</p>	W 460			

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

PRINTED: 05/12/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G202	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/11/2021
--	---	--	---

NAME OF PROVIDER OR SUPPLIER LIFE, INC LAKEVIEW	STREET ADDRESS, CITY, STATE, ZIP CODE 102 MIDWAY LANE ROANOKE RAPIDS, NC 27870
---	--

(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 460	<p>Continued From page 8</p> <p>Interview on 5/11/21 with the QIDP and HC confirmed client #1 should have received milk with her breakfast.</p> <p>Interview on 5/11/21 with the facility Nurse revealed client #1 has issues with constipation. The Nurse revealed that the 4 ounces of milk each morning at breakfast in addition to daily medications for constipation is what the facility was doing to regulate client #1's bowels. The facility Nurse confirmed client #1 should have been given 4 ounces of milk at breakfast.</p>	W 460		
-------	---	-------	--	--



June 4, 2021

Mr. Justin Foster, MPA, QIDP
Facility Survey Consultant I
Division of Health Service Regulation
Mental Health Licensure and Certification
2718 Mail Service Center
Raleigh, North Carolina 27699-2718

Re: Plan of Correction
LIFE, Inc. /Lakeview Group Home

Dear Mr. Foster,

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

A handwritten signature in blue ink that reads 'Susan P. Ayres'.

Susan P. Ayres
Director of ICF/IID Services

ART
Enclosure