STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G028	A. BUILDING _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC WILLIAM STREET HOME	407 NORTH WILLIAM 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 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure there was no conflict of interest pertaining to guardianship for 1 of 4 audit clients (#6). The findings include:The findings include: A review on 6/2/21 of Client #6's Individual Program Plan (IPP) revealed that the Director was appointed his guardian on 2/1/05. The Director, formerly a direct care professional, had become acquainted with Client #6 while working with him in a previous group home. Client #6's mother was deceased and there was very limited contact with other family members. An interview on 6/2/21 with the Director revealed that she was promoted to her current position in March 2021. She explained that six months ago, she made contact with Client #6's brothers and had explored them getting more involved with his care, but they did not follow through. The Director had not explored other viable options for guardianship. The Director also shared that the Vice President of the facility was aware of the situation and did not view her serving as Client #6's guardian as a conflict of interest.	W 125	W 125 The facility will pursue new guardianship by exploring various avenues to include family, local agencies and other resources. A motion to modify guardian will be presented to the courts. Once approved, all appropriate notifications will be made, appropriate parties informed. Facility will ensure consumer is involved in the process and all documentation is updated in his records. DHSR - Mental Health JUL 2 2021 Lic. & Cert. Section	8-2-2021
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must	W 217		

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

Director/ICF-IID — 6/29/21

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G028	A. BUILDING _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC WILLIAM STREET HOME	407 NORTH WILLIAM 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 217	Continued From page 1 include nutritional status. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure 1 newly admitted client's (#5) nutritional assessment was completed within 30 days of admission. The finding is: A review on 6/1/21 of Client #5's Individual Program Plan (IPP) dated 4/22/21 revealed he has admitted on 4/16/2020 and did not have a nutritional assessment performed by the dietician. A further review on 6/2/21 of Client #5's record produced a Nursing Evaluation dated 7/11/19 that outlined dietary orders. An interview on 6/2/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she could not find a current nutritional assessment for Client #5. The QIDP presumed the facility was using the dietary orders that were active on Client #5's admission, from another residential provider. An interview on 6/2/21 with the QIDP #2 revealed that an annual nutritional assessment should be done at admission and annually with the dietician making a meal observation.	W 217	W 217 The facility will ensure all newly admitted clients will receive nutritional assessments within 30 days of admission and annually for existing clients. QP I will contact the dietician for completion of nutritional assessments upon admission and monthly prior to any upcoming team meetings. Staff will be in-serviced on any updated nutritional assessments recommendations, guidelines or orders. All information will be included in the therap system and monitored atleast monthly by the QP during the monthly chart reviews and bi-annually during chart audits.	8-2-2021
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.	W 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G028	A. BUILDING _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC WILLIAM STREET HOME	407 NORTH WILLIAM 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 263	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. The affected 2 of 3 audit clients (#5 and #6). The findings are: A. Review on 6/2/21 of Client #5's Behavior Support Plan (BSP) dated 10/4/20 revealed objectives to reduce physical aggression, vocal agitation, defiance and property destruction. The BSP incorporated the use of Seroquel. An additional review of the record revealed that Client #5 had co-guardians and they did not sign the renewal consent for the BSP by the 5/4/21 expiration date. B. Review on 6/2/21 of Client #6's BSP dated 11/17/20 revealed objectives to reduce frustration, punching, defiance and food stealing. An additional review of the record revealed that Client #6 guardian did not sign the renewal consent for the BSP by the 5/17/21 expiration date. An interview on 6/2/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that last month the BSP was reviewed and the document was left at the corporate office for the other signatures to be obtained. She has not received a new signed BSP consents for either Client #5 or Client #6's guardians. An interview on 6/2/21 with the guardian for Client #6, who is also the Director of the program, revealed that the consent gets mailed to her home address. She did not recall signing any consent last month for Client #6.	W 263	W 263 The facility will ensure the clients consents medications match the current BIP plan with signatures from the legal guardian and co-guardian. All current consents will be reviewed to ensure all information is included. Updated consents will be received and filed. The QP I will ensure compliance with this regulation by reviewing all consents at least monthly during chart reviews to ensure appropriate medications are listed along with appropriate signatures from the legal guardian/co-guardianship and ensure they are with date range. Findings will be recorded and filed in the facility inspection notebook.	8-2-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G028	A. BUILDING _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC WILLIAM STREET HOME	407 NORTH WILLIAM 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 263	Continued From page 3 An interview on 6/2/21 with the QIDP #2 revealed that the bi-annual consents should be sent out for signatures of the guardians, after the Human Rights Committee meets in January.	W 263		
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 staff interview, the facility failed to conduct fire drills during varied hours. This had the potential to affect 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The findings include: A review on 6/1/21 of the facility's Fire Drill Reports revealed on 6/18/20 the drill was held at 5:50 AM. On 8/12/20 the drill was held at 4:17 AM. On 12/12/20, the drill was held at 6:00 AM. On 3/12/21 the drill was held at 4:52 AM. An interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she has worked at the home for less then six months. The QIDP acknowledged that she scheduled the drills toward the end of the shift and was not aware that the drills should be held under varied conditions. An interview with the QIDP #2 on 6/2/21 revealed that third shift fire drills should also occur between 2:00 AM-4:00 AM.	W 441	W 441 The facility will ensure the disaster drills are completed during various of times under varied conditions. Staff will be in-serviced on documentation of times drills should be completed. QP will complete a fire drill record monthly indicating the timeframe each drill should be completed. This will be monitored ongoing by the Hab Coordinator and QP during random inspections and monthly during QP Checklist	8-2-2021
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G028	A. BUILDING _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC WILLIAM STREET HOME	407 NORTH WILLIAM 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 460	Continued From page 4 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 staff interviews, the facility failed to ensure 4 of 6 audit clients (#1, #3, #5 and #6) received specially-prescribed diets as indicated. The findings include: A. During lunch meal observations in the home on 6/1/21 at 12:15 PM, Clients #1 and #6 received 1" cut sandwiches with meal. A review on 6/1/21 of Client #1's Individual Program Plan (IPP) dated 9/24/20 revealed a regular diet and food should be cut into 1/2" pieces. An additional review on 6/1/21 of Client #6's IPP dated 6/4/20 revealed a finely chopped diet of 1/4" pieces. Review on 6/2/21 of a diagram in the facility's kitchen identifying choking hazards had pictures of 1/4" and 1/2" food piece food that were smaller then the food observed served at lunch on 6/1/21. Interview on 6/1/21 with Staff B revealed that she cut up all of the modified sandwiches at once, into what she perceived as 1/2" bite size pieces. B. During dinner meal observations in the home on 6/1/21 at 5:40 PM, Staff A had a container of cubed bread cut into 1/2" pieces, that was served to Clients #1, #3, #5 and #6. A review of Client #6's IPP dated 6/4/20 revealed a finely chopped 1/4" bite-pieces diet.	W 460	W 460 The facility will ensure all receive a nourishing, well balanced diet including modified and specially prescribed diets to include portions size, texture, proper condiments as indicated on the physician's orders and dietary assessments. All will be reviewed by team. Any changes will be reviewed and Staff will be in-serviced on dietary assessments. Nurse will complete a training on size portions along with completing an in-service. Mealtimes will be monitored by the Hab Coordinator and QP during random inspections for a minimum of three times per month. These observations will be documented in the FIDS app.	8-2-2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G028	A. BUILDING _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC WILLIAM STREET HOME	407 NORTH WILLIAM 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 460	Continued From page 5 A review of Client #5's IPP dated 4/22/21 revealed a regular diet. A review of Client #3's IPP dated 10/14/20 revealed a regular diet of 1" bite-size pieces. A review of Client #1's IPP dated 9/24/20 revealed a regular diet of 3/4-1" bite-size pieces. Review on 6/2/21 of a diagram in the facility's kitchen identifying choking hazards had pictures of bite-size pieces of 1/4", 1/2" and 1". The food served at dinner did not offer specified bite-size pieces based on the client's dietary order. Interview on 6/1/21 with the nurse revealed that she reviews the diet orders and trains the staff, how to modify the diet. A diagram is posted in the kitchen to give staff guidance. C. During breakfast meal observations in the home on 6/2/21 at 8:00 AM, Staff B made breakfast and transferred regular grape jelly into a serving bowl. Clients were served biscuits along with their meal. Clients #1, #3, #5 and #6 used the regular grape jelly on their biscuits. There was no sugar free jelly available for clients in the refrigerator or pantry. A review of Client #1's IPP dated 9/24/20 revealed a sugar free condiments diet. A review of Client #3's IPP dated 10/14/20 revealed a sugar free condiments diet. A review of Client #5's IPP dated 4/22/21 revealed a sugar free condiments diet.	W 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G028	A. BUILDING _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC WILLIAM STREET HOME	407 NORTH WILLIAM 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 460	Continued From page 6 A review of Client #6's IPP dated 6/4/20 revealed a sugar free condiments diet. An interview on 6/2/21 with Staff B revealed that there was no sugar free jelly available. Staff B was not aware that some of the clients should not get regular jelly. An interview on 6/2/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that either the Habilitation Coordinator (HC) or her does the grocery shopping for the clients in the home. She shared during the pandemic, the facility had started online grocery shopping and thought it was possible that sugar free jelly may have been substituted by the store if it was out of stock. The QIDP had not noticed that there was no sugar free jelly in the house and that it was a requirement for several clients needed to use this product. D. During breakfast meal observations in the home on 6/2/21 at 8:00 AM, Client #5 a second serving of scrambled eggs. A review of Client #5's Nursing Evaluation dated 7/11/19 revealed a low cholesterol diet with double portions except beef, pork and eggs. An interview on 6/2/21 with the QIDP revealed that diet orders are reviewed by either the QIDP or HC and then posted on the refrigerator. The QIDP was not aware that there were discrepancies in the dietary orders for Client #5 amongst the physician's orders and the IPP. An interview on 6/2/21 with the QIDP #2 revealed that staff should follow the dietary orders.	W 460		