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

PRINTED: 06/08/2022
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
	34G167	A. BUILDING ______ B. WING ______	06/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDLEWOOD GROUP HOME	103 WOOD GLENN ROAD 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 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4 had the right to clothing of an appropriate size/fit and the right to access his clothing. This affected 1 of 3 audit clients. The findings are: A. During observations throughout the survey on 6/6 - 6/7/22, client #4 wore pants which were too big. The pants were extremely long with approximately 3 - 4 inches of excess fabric bunched on top of his feet. In addition, his pants fell well below his waist line causing his buttocks to frequently be exposed when he sat on the floor or bent over. Further observations of client #4's clothing revealed numerous pants with varying sizes including large, x-large and 2x-large. Review on 6/7/22 of client #4's Individual Program Plan (IPP) dated 9/9/21 revealed he can dress and undress himself and needs reminders to pull his pants up. Additional review of the plan indicated client #4 requires assistance from his guardian to ensure his rights. Interview on 6/7/22 with the Home Manager confirmed client #4's pants were too big. Interview on 6/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated new clothing was purchased for client #4 in March of	W 137	W137: The facility will ensure the rights of all consumers to include the right to retain and use persona possessions and clothing. This will include that all consumers clothing fits appropriately at all times. The QP I and Habilitation Coordinator will ensure that each individual is provided with clothing in which fits appropriately as well as in sufficient amount. In addition, clothing accessories such as a belt will be utilized as warranted and training will be provided to each individual to promote independence in the area of self-care. Facility will ensure consumers have access to all belongings at all times unless otherwise indicated in their BSP. All staff will be in serviced to ensure appropriate consumer appearance is monitored daily. Routine observations and a minimum of 3 inspections per month will be completed by the QPI and Habilitation Coordinator on an ongoing basis.	8/7/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Director of ICF
(X6) DATE: 6-21-22

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.

DHSR - Mental Health
JUN 2 9 2022
Lic. & Cert. Section

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W 137	Continued From page 1 this year. The QIDP acknowledged client #4's pants were too big. B. During observations of client #4's bedroom on 6/7/22 revealed his closet and dresser drawers were largely empty and only contained a few items including three shirts, a robe and several socks. After being questioned regarding the limited amount of clothing in client #4's bedroom, the Home Manager (HM) began to search for the client's clothing in other areas of the home. Later observations revealed client #4's clothing locked in a hall closet of the home. Interview on 6/7/22 with the HM revealed client #4 sometimes removes his clothes from his room and puts them in the dryer. Review on 6/7/22 of client #4's IPP indicated he requires assistance from his guardian to ensure his rights. Interview on 6/7/22 with the QIDP confirmed client #4 will often take clothes out of his bedroom and put them in the dryer or other areas of the home and staff had locked his clothing in the hall closet for this reason.	W 137		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the	W 227		

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W 227	Continued From page 2 facility failed to ensure 1 of 3 audit clients (#4) individual program plan (IPP) included effective training to meet the client's needs with complying with evacuations during fire drills. The finding is: Review on 6/7/22 of the IPP for client #4 dated 9/9/21 revealed it was identified informal training was offered to give him verbal prompts to evacuate during a fire drill. A further review of the behavior intervention plan (BIP) dated 8/16/21 revealed client #4 had a targeted behavior of defiance. If client #4 did not comply, staff may request along with the least amount of physical assistance (graduated guidance) to promote compliance. Review on 6/7/22 of the facility's fire drills logs revealed the following information on client #4's participation. 6/12/21 - Staff L recorded a fire drill 11:28pm, when she was alone on duty. It revealed client #4 would not get out of bed and refused to leave his room. Staff L stated her concern was in a real scenario, client #4 would be injured in a fire. 9/6/21 - Staff L recorded a fire drill at 11:55am and revealed client #4 would not leave the house and became aggressive with staff. Client #4 "flopped on the floor", refused to get up and pushed staff away when redirected. 12/2/21 - Staff L recorded a fire drill at 1:04am and revealed client #4 would not get out of bed. 1/10/22 - A fire drill was conducted at 2:30 pm and revealed client #4, who was ambulatory, took his time leaving the house and would not allow staff to help.	W 227	W227- The facility will ensure that each consumer's individual plan includes objectives to meet each consumer's needs in the area of safety. Each consumer will be reassessed to determine services warranted. All staff will be in-serviced on the findings. This plan of correction will be monitored by the habilitation coordinator and the QP on an ongoing basis through monthly inspections, a minimum of 3 per month.	8/7/22

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W 227	Continued From page 3 4/10/22 - A fire drill was conducted at 10:30am and revealed client #4 ran out of the house, along with clients #2 and #5 and stood in the street. Interview on 6/7/22 with the Home Manager (HM) revealed she reviewed all fire drill reports and was present during the drill in December, 21 when client #4 would not get out of bed. The HM stated staff were using verbal prompts to encourage client #4 to participate but there had been no other interventions developed to improve client #4's compliance during their drills. The HM acknowledged that she did not know how many incidents of non-compliance client #4 had displayed with fire drills over the past year. Interview on 6/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she was aware if client #4 was sleepy, he does not get up as quickly. The QIDP stated client #4 needed extra time to get out of the house and that staff can re-enter the home to get him, if he refuses to evacuate. The QIDP stated that another technique to get client #4 out of bed was to take the blanket off him while in bed, and then lead him by the hand, out of the house.	W 227	W240: The facility will ensure that all clients receive education and training in areas of self-care. Each individual will be reviewed/evaluated on their self-care needs and guidelines/training goals will be implemented as warranted. All staff will receive additional training to address each individual's needs. OT will be contacted for reevaluation. The QP and Hab. Coordinator will monitor on an ongoing basis utilizing monthly inspection forms that will consist of no less than 3 per month.	8/7/22
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included specific information to support client #4's independence	W 240		

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W 240	Continued From page 4 with wearing his shoes. This affected 1 of 3 audit clients. The finding is: During observations at the day program on 6/6/22, client #4 did not wear shoes. The client walked throughout the facility with only socks on his feet while holding his shoes in his hands or placing them beside him as he sat on the floor. While at the day program, client #4 was not observed to be prompted or encouraged to wear his shoes. Interview on 6/7/22 with Staff F revealed client #4 will wear his shoes "some days" and other days he would not. Additional interview indicated they "redirect" him to put them on. Review on 6/6/22 of client #4's IPP dated 9/9/21 revealed strengths to put his shoes on. Additional review of the IPP did not include specific guidelines to support the client with actively wearing his shoes. Interview on 6/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated client #4 often will not wear his shoes; however, staff should be prompting him to put them on.	W 240		
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.	W 249	W249: The facility will ensure that all consumers receive continuous active treatment which will include needed interventions and services to achieve objectives that have been identified to include their behavior intervention plans. Each staff will be in serviced to ensure they follow all steps written in the BIP. This plan will be monitored by the QPI and Habilitation Coordinator on an ongoing basis through scheduled inspections a minimum of 3x per month.	8/7/22

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W 249	Continued From page 5 This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure each client received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of behavior plan implementation. This affected 1 of 3 audit clients (#4). The findings are: A. During evening observations in the home on 6/6/22 at 5:05pm, 5:14pm and 5:15pm, 5:35pm, 5:36pm and 5:46pm client #4 intentionally knocked a chair from the kitchen table onto the floor. With each incident, various staff in the area prompted him to "Stop" and to pick up the chair. Client #4 was not prompted to another area of the home. Interview on 6/6/22 with Staff E revealed when client #4 throws a chair to the floor, they normally "tell [Client #4] to "Stop" and to pick up" the chair. Review on 6/7/22 of client #4's Behavior Intervention Plan (BIP) dated 8/16/21 revealed an objective to reduce the frequency of defined behavior episodes to 12 or less per month for a period of 8 consecutive months. The plan identified target behaviors of defiance, aggression/SIB and property destruction. Additional review of the BIP defined property destruction as "intentional abuse or misuse of property (throwing/knocking over items, hitting tables or walls, etc)." Further review of the plan noted, "...If [Client #4's] behaviors continue and becomes more aggressive (3 or more incidents)	W 249		

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W 249	Continued From page 6 staff will prompt/escort him to an area of the workshop/group home away from others until he calms for 3 minutes without target behavior occurrences." Interview on 6/7/22 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) revealed client #4's BIP was current and should be followed as written. B. During mealtime observations in the home on 6/6 - 6/7/22, client #4 sat away from other clients at a lowered countertop area in the kitchen to consume his dinner and breakfast meals. The client was not offered the choice to consume his meal with other clients at the dining room table. Interview on 6/7/22 with Staff B and Staff G revealed client #4 does not sit at the dining room table with other clients because he will throw items from the table. Review on 6/7/22 of client #4's BIP dated 8/16/21 revealed, "[Client #4] should be monitored closely at all mealtimes due to him becoming upset and throwing/pushing plate, cups etc. If this occurs, [Client #4] will be removed from the table and placed at a table alone to finish his meal if he is sitting with others..." Interview on 6/7/22 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) revealed client #4's BIP was current and should be followed as written.	W 249		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria	W 252		

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W 252	Continued From page 7 specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure data relative to the accomplishment of criteria specified in objectives was documented in measurable terms. This affected 1 of 3 audit clients (#4). The finding is: During evening observations in the home on 6/6/22 at 5:05pm, 5:14pm and 5:15pm, client #4 intentionally knocked a chair from the kitchen table onto the floor. With each incident, various staff in the area prompted him to "Stop" and to pick up the chair. Interview on 6/6/22 with Staff E revealed throwing chairs to the floor was a target behavior for client #4 and his target behaviors should be documented. Review on 6/7/22 of client #4's Behavior Intervention Plan (BIP) dated 8/16/22 revealed an objective to reduce the frequency of defined behavior episodes to 12 or less per month for a period of 8 consecutive months. The plan identified target behaviors of defiance, aggression/SIB and property destruction. Further review of the BIP indicated "...data should be recorded by all staff working with [Client #4] across his waking day." Review on 6/7/22 of client #4's electronic behavior data sheet revealed the behavior	W 252	W252 The facility will ensure that all consumers behaviors are accurately and timely documented as specific to their individual behavior intervention plan. The team will ensure that the criteria specified in the plan is documented in measurable terms. Each staff will be in serviced to ensure they follow all steps written in the BIP as well as documentation requirements. This plan will be monitored by the home managers on an ongoing basis through scheduled inspections a minimum of 3x per month as well as monthly data review by the Program Specialist and team members and documented in the monthly QP review.	8/7/22

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W 252	Continued From page 8 incidents on 6/6/22 at 5:05pm, 5:14pm and 5:15pm were not documented. Interview on 6/7/22 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) confirmed all of client #4's target behaviors should be documented as indicated.	W 252		
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 #4's inappropriate behavior was included in a formal active treatment plan. This affected 1 of 3 audit clients. The finding is: During observations of client #4's bedroom on 6/7/22 revealed his closet and dresser drawers were largely empty and only contained a few items including three shirts, a robe and several socks. After being questioned regarding the limited amount of clothing in client #4's bedroom, the Home Manager (HM) began to search for the client's clothing in other areas of the home. Later observations revealed client #4's clothing locked in a hall closet of the home. Interview on 6/7/22 with the HM revealed client #4 sometimes removes his clothes from his room and puts them in the dryer.	W 288	W288: The facility will ensure that all techniques to manage inappropriate behaviors are included in an active treatment program. All plans will be reviewed to ensure proper techniques and the appropriateness of each. Staff will receive updated training as to the appropriate/approved techniques. A Core Team meeting will be held to discuss any changes or formulate an active treatment program to address each consumer's current needs and will be included in the training. This plan of correction will be monitored on an ongoing basis through monthly inspections (minimum of 3 per month) by the home manager as well as documented in monthly review of data.	8/7/22

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W 288	Continued From page 9 Review on 6/7/22 of client #4's Behavior Intervention Plan (BIP) dated 8/16/22 revealed an objective to reduce the frequency of defined behavior episodes to 12 or less per month for a period of 8 consecutive months. The plan identified target behaviors of defiance, aggression/SIB and property destruction. Additional review of the BIP did not include a technique of restricting access to his clothing to address inappropriate behaviors. Interview on 6/7/22 with the QIDP confirmed the client will often take clothes out of his bedroom and put them in the dryer or other areas of the home and staff had locked his clothing in the hall closet for this reason.	W 288		
W 448	EVACUATION DRILLS CFR(s): 483.470(i)(2)(iv) The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement corrective measures after problems with fire drills were repeatedly identified. This had the potential to affect 1 of 3 audit clients (#4). The finding is: A. Review on 6/7/22 of the facility's fire drills logs revealed the following information on client #4's participation. 6/12/21 - Staff L recorded a fire drill 11:28pm, when she was alone on duty. It revealed client #4 would not get out of bed and refused to leave his room. Staff L stated her concern was in a real scenario, client #4 would be injured in a fire.	W 448	W448: The facility will ensure that all problems during evacuations and fire drills are evaluated. The facility will implement corrective actions should problems with drills are repeatedly identified. Each consumer will be assessed. A Core Team meeting will be held to formulate an active treatment program to address each consumer's current needs in the area of fire and safety. Staff will be in-serviced accordingly. This plan of correction will be monitored on an ongoing basis through monthly inspections (minimum of 3 per month) by the home managers.	8/7/22

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W 448	Continued From page 10 9/6/21 - Staff L recorded a fire drill at 11:55am and revealed client #4 would not leave the house and became aggressive with staff. Client #4 "flopped on the floor", refused to get up and pushed staff away when redirected. 12/2/21 - Staff L recorded a fire drill at 1:04am and revealed client #4 would not get out of bed. 1/10/22 - A fire drill was conducted at 2:30 pm and revealed client #4, who was ambulatory, took his time leaving the house and would not allow staff to help. 4/10/22 - A fire drill was conducted at 10:30am and revealed client #4 ran out of the house, along with clients #2 and #5 and stood in the street. B. Review on 6/7/22 of the facility's quarterly Safety Committee Minutes revealed the following response: 8/20/21, 11/7/21 and 5/10/22 revealed no recommendations on handling fire drills with non-compliant clients. Interview on 6/7/22 with the Home Manager (HM) revealed client #4 had long standing behaviors during fire drills. She acknowledged that she reviewed the monthly drills as well as their Quality Assurance/Quality Indicator (QA/QI) personnel. The HM confirmed that there have been no changes in getting client #4 to be more cooperative with fire drills. Interview on 6/7/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed there had been no new recommendations on addressing client #4's non-compliance during fire	W 448		

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W 448	Continued From page 11 drills evacuations.	W 448		

June 21, 2022

Ms. Esther Moore, BSW, 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. / Idlewood Group Home

Dear Ms. Moore,

Enclosed please find our written plan of correction for the recent survey at our Idlewood 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 P. Ayres
Director of ICF/IID Services

Enclosure