DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED								
CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO.								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		34G285	B. WING			10/25/2022		
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
	NINE FOOT ROAD			1229 NINE FOOT ROAD				
,				N	EWPORT, NC 28570			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIZ TAG	IX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)		W 2	63				
	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. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure written informed consent was obtained from client #4's guardian for his restrictive Behavior Support Plan (BSP). This affected 1 of 3 audit clients. The finding is: Review on 10/24/22 of client #4's BSP dated 3/24/21 revealed an objective to reduce the frequency of defined behavior episodes to 1 or less per month for 8 consecutive months. Additional review of the plan noted the use of Zyprexa Zydis to address his inappropriate behaviors. Further review of the record did not include a current written informed consent for client #4's BSP. Interview on 10/25/22 with the Qualified Intellectual Disabilities Professional (QIDP) indicated no current written consent was available for review.							
W 340	other members of the appropriate protection measures that inclust training clients and health and hygiene	(5)(i) ust include implementing with ne interdisciplinary team, ve and preventive health de, but are not limited to staff as needed in appropriate	W 3	40				
	Based on observat	ions, interview and record ailed to ensure staff were						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 11/07/2022

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.

CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		34G285	B. WING _		10	10/25/2022
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		120/2022
LIFE, INC	NINE FOOT ROAD	GROUP HOME		1229 NINE FOOT ROAD NEWPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
W 340	protocols and proc The finding is: Upon arrival to the	to implement visitation edures regarding COVID-19. home on 10/24/22 at 3:35pm	W 34	0		
	temperature was n screening question Review on 10/25/2	15am, the surveyor's ot taken and no COVID-19 is were asked. 2 of the facility's COVID-19 rm revealed the visitor's				
	temperature should asked.	d be taken and five questions /22 with the Qualified				
W 460	Intellectual Disabili confirmed all visito screened for COVI temperature taken questions.	ties Professional (QIDP) rs to the home should be D-19 including having their and asked the five screening ITION SERVICES	W 46	0		
		eceive a nourishing, including modified and d diets.				
	Based on observa interviews, the faci specially ordered d	is not met as evidenced by: tions, record review and lity failed to ensure client #1's liet was followed as written. audit clients. The finding is:				
	10/24/22 at 5:50pm serve herself a sing	servations in the home on n, client #1 was assisted to gle serving of hash browns, nd a biscuit. The items were a				

FORM CMS-2567(02-99) Previous Versions Obsolete

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		AND HUMAN SERVICES				FORM	11/07/2022 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	34G285		B. WING			10/25/2022		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
LIFE, INC	NINE FOOT ROAD	GROUP HOME	1229 NINE FOOT ROAD NEWPORT, NC 28570					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 460	ground consistency on the menu, client Interview on 10/25/ client's diet was pos this is what they fol Review on 10/24/22 refrigerator in the h 1/13/22 and the clie noted she consume with "double portior non-starchy vegeta Interview on 10/25/ confirmed client #1 servings of meats,	 Although turkey bacon was #1 was not served bacon. 22 with Staff E revealed each sted on the refrigerator and low. 2 of a diet list posted on the ome, client #1's IPP dated ent's current physician's orders a ground consistency diet as of meat, eggs and 	W 4	460				

Facility ID: 944844

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