PRINTED: 11/10/2022 FORM APPROVED OMB NO. 0938-0391

STREET ADDRESS, CITY, STATE, ZIP CODE 907 OAKDALE AVE NEW BERN, NC. 28560 STREET ADDRESS, CITY, STATE, ZIP CODE 907 OAKDALE AVE NEW BERN, NC. 28560	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
LIFE, INC OAKDALE HOME LIFE, INC OAKDALE HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAG E 039 EP Testing Requirements CFR(s): 483.475(d)(2) \$416.54(d)(2), \$441.113(d)(2), \$441.184(d)(2), \$460.84(d)(2), \$485.727(d)(2), \$485.727(d)(2), \$485.625(d)(2), \$485.727(d)(2), \$485.625(d)(2), \$485.625(d)(2), \$485.727(d)(2), \$485.727(d			34G090	B. WING			1	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) E 039 EP Testing Requirements CFR(s): 483.475(d)(2), \$441.184(d)(2), \$460.844(d)(2), \$482.15(d)(2), \$483.73(d)(2), \$483.475(d)(2), \$484.102(d)(2), \$485.920(d)(2), \$4					9	07 OAKDALE AVE	10/	10/2022
CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.625(d)(2), §485.727(d)(2), §485.68(d)(2), §481.12(d)(2), §494.62(d)(2). "[For ASCs at §416.54, CORFs at §485.68, OPO, "Organizations" under §445.727, CMHCs at §485.920, RHCs/FOHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) if the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plant, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise or or (B) A mock diseaser drilt; or	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		CFR(s): 483.475(d) §416.54(d)(2), §418 §460.84(d)(2), §482 §483.475(d)(2), §48 §485.625(d)(2), §48 §491.12(d)(2), §494 *[For ASCs at §416 "Organizations" und §485.920, RHCs/FG Facilities at §494.62 (2) Testing. The [facto test the emergen must do all of the formulate of the for	3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.920(d)(2), 4.62(d)(2). 3.54, CORFs at §485.68, OPO, der §485.727, CMHCs at QHCs at §491.12, and ESRD 2]: cility] must conduct exercises acy plan annually. The [facility] ollowing: ull-scale exercise that is every 2 years; or unity-based exercise is not at a facility-based functional ears; or y] experiences an actual de emergency that requires hergency plan, the [facility] is jing in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: eale exercise that is or individual, facility-based or redrill; or cise or workshop that is led by		039			(VG) 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.

Facility ID: 922323

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED			
		34G090	B. WING		10	C / 18/2022
	PROVIDER OR SUPPLIER C OAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP CO 907 OAKDALE AVE NEW BERN, NC 28560	•	710/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
E 039	a facilitator and incla a narrated, clinically scenario, and a set directed messages designed to challen (iii) Analyze the [facility analyze the analyze	udes a group discussion using y-relevant emergency of problem statements, or prepared questions ge an emergency plan. Sility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. 18.113(d):] Dices that provide care in the energency plan at least poice must conduct the emergency plan at least poice must do the following: full-scale exercise that is every 2 years; or unity based exercise is not that an individual facility based every 2 years; or experiences a natural or experiences a natural or exercise or individual sexercise or individual onal exercise following the ency event. Sitional exercise every 2 years, the full-scale or functional exercise or functional eagraph (d)(2)(i) of this section may include, but is not limited cale exercise that is or a facility based functional	EC	039		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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E 039	a narrated, clinically scenario, and a set directed messages designed to challen (3) Testing for hosp care directly. The hexercises to test the year. The hospice (i) Participate in an is community-based (A) When a community-based functi (B) If the hospice eman-made emerge the emergency plar engaging in its next based or facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-scommunity-based of exercise; or (B) A mock disasted (C) A tabletop exerting facilitator that include narrated, clinically-rand a set of problem messages, or prepare challenge an emerging (iii) Analyze the homaintain document	of problem statements, , or prepared questions ge an emergency plan. sices that provide inpatient hospice must conduct e emergency plan twice per must do the following: hannual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or experiences a natural or hocy that requires activation of hat he hospice is exempt from the emergency event. Iditional annual exercise of the emergency event. Iditional annual exercise that hot limited to the following: cale exercise that is or a facility based functional er drill; or recise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. spice's response to and ation of all drills, tabletop ergency events and revise the	EC			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		34G090	B. WING _		10	C / 18/2022	
	PROVIDER OR SUPPLIER COAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP CO 907 OAKDALE AVE NEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 039	*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [PF conduct exercises at twice per year. The do the following: (i) Participate in an is community-based (A) When a community-based function (B) If the [PRTF, Ho actual natural or ma requires activation (facility-based functionset of the emerging (ii) Conduct an and that may include following: (A) A second full-scommunity-based of functional exercises (B) A mock (C) A tabletop of led by a facilitator at discussion, using a emergency scenari statements, directed questions designed plan. (iii) Analyze the maintain document	1.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan annual full-scale exercise that d; or unity-based exercise is not annual individual, onal exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the rom engaging in its next community based or individual, onal exercise following the ency event. [additional] annual exercise or le, but is not limited to the cale exercise that is or individual, a facility-based or disaster drill; or exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency at [facility's] response to and ation of all drills, tabletop ergency events and revise the cy plan, as needed.	E 03	9			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
		34G090	B. WING		10	C / 18/2022
	PROVIDER OR SUPPLIER C OAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP COE 907 OAKDALE AVE NEW BERN, NC 28560	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	(2) Testing. The PA exercises to test the annually. The PACI following: (i) Participate in an is community-based (A) When a community-based facility-based function (B) If the PACE expressible, conducting facility-based functions and the emergency plarengaging in its next based or individual, exercise following the exercise under participate is conducted that must be following: (A) A second full-second full-second functional exercises (B) A mock disasted (C) A tabletop exercise a facilitator and inclusing a narrated, clusing a narrated, clus	CE organization must conduct a emergency plan at least organization must do the annual full-scale exercise that d; or unity-based exercise is not than annual individual, onal exercise; or periences an actual natural or not that requires activation of the pace is exempt from the required full-scale community, facility-based functional the onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section that is not limited to cale exercise that is or individual, a facility based for ear drill; or the recise or workshop that is led by ludes a group discussion, inically-relevant emergency of problem statements, or prepared questions age an emergency plan. CE's response to and ation of all drills, tabletop ergency events and revise the relation as needed.	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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	PROVIDER OR SUPPLIER C OAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP CO 907 OAKDALE AVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
E 039	test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a community-based function (B) If the [LTC facility-based function actual natural or marequires activation of LTC facility is exemined a full-scale individual, facility-based following the onset (ii) Conduct an additional exercise; (B) A mock disaste (C) A tabletop exert a facilitator includes narrated, clinically-rand a set of problem essages, or prepare challenge an emergical maintain documexercises, and emergical facility of the set the emergent The ICF/IID must desired.	plan at least twice per year, aced staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not an annual individual, onal exercise. ty] facility experiences an an-made emergency that of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. Individual, facility based or an individual, facility based or ar drill; or cise or workshop that is led by a group discussion, using a relevant emergency scenario, an statements, directed ared questions designed to gency plan. To facility] facility's response to mentation of all drills, tabletop ergency events, and revise the is emergency plan, as needed. 83.475(d)]: F/IID must conduct exercises ocy plan at least twice per year.	EC	39		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G090	B. WING_			C / 18/2022		
	PROVIDER OR SUPPLIER C OAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 907 OAKDALE AVE NEW BERN, NC 28560				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
E 039	accessible, conduction facility-based functional emergency plarengaging in its next community-based of functional exercise emergency event. (ii) Conduct an add may include, but is (A) A second full-socommunity-based of functional exercise; (B) A mock disaste (C) A tabletop exercise a facilitator and inclusing a narrated, clusing a narrated, cl	d; or unity-based exercise is not that an annual individual, onal exercise; or. Experiences an actual natural or noty that requires activation of an, the ICF/IID is exempt from a required full-scale or individual, facility-based following the onset of the sitional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or ar drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, or prepared questions ge an emergency plan. E/IID's response to and action of all drills, tabletop ergency events, and revise the explan, as needed. E-102] HHA must conduct exercises acy plan at HHA must do the following: cull-scale exercise that is	E 03	39				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G090	B. WING			C 18/2022
	PROVIDER OR SUPPLIER COAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 907 OAKDALE AVE NEW BERN, NC 28560		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	or man-made emerof the emergency pengaging in its next community-based of functional exercise emergency event. (ii) Conduct an add opposite the year the exercise under parties conducted, that limited to the follow (A) A second for community-based of functional exercises (B) A mock disassion, using a emergency scenaristatements, directed questions designed plan. (iii) Analyze the HH documentation of a emergency events, emergency plan, as *[For OPOs at §486 (d)(2) Testing. The to test the emerger following: (i) Conduct a paper workshop at least as led by a facilitator ad discussion, using a emergency scenarior discussion and the services of the emergency scenarior discussion, using a emergency scenarior discussion, using a emergency scenarior discussion discussion, using a emergency scenarior discussion discussion, using a emergency scenarior discussion discuss	experiences an actual natural regency that requires activation plan, the HHA is exempt from a required full-scale or individual, facility based following the onset of the retail itional exercise every 2 years, the full-scale or functional agraph (d)(2)(i) of this section at may include, but is not ing: Ill-scale exercise that is or an individual, facility-based for exercise or workshop that is and includes a group narrated, clinically-relevant o, and a set of problem d messages, or prepared to challenge an emergency A's response to and maintain and revise the HHA's is needed.	E 038			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		34G090	B. WING _		10	C / 18/2022	
	PROVIDER OR SUPPLIER C OAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP 907 OAKDALE AVE NEW BERN, NC 28560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
E 039	questions designed plan. If the OPO exman-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[RNCHIs at §403. (d)(2) Testing. The exercises to test th must do the followin (i) Conduct a paper least annually. A tare discussion led by a clinically-relevant e of problem statement of problem statement of problem statement and emergency plan. (ii) Analyze the RNI maintain document and emergency plan, as This STANDARD in Based on record refacility failed to compreparedness plan clients (#1, #2, #3, Review on 10/18/22) preparedness plan annual tabletop activity or activity could be locally as the open activity as the open activity could be locally as the open activity and the open activity as the	I to challenge an emergency periences an actual natural or ncy that requires activation of n, the OPO is exempt from a required testing exercise of the emergency event. O's response to and maintain II tabletop exercises, and and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: 1-based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCI's response to and ation of all tabletop exercises, ents, and revise the RNHCI's eviews and interviews, the duct to test the emergency. This potentially affected all #4, and #5) living in the home. 2 of the emergency dated 12/9/21, revealed an ivity on 3/3/21. No other full-scale, community-based	E 03	9			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONST				E SURVEY PLETED
		34G090	B. WING					C 18/2022
	PROVIDER OR SUPPLIER C OAKDALE HOME			907 OAKE	ODDRESS, CITY, STATE, ZIP C DALE AVE ERN, NC 28560	ODE	10/	10/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
E 039 W 249	ICF revealed that s tabletop activity.	he was unable to locate a MENTATION	E 0					
	formulated a client's each client must re treatment program interventions and s and frequency to su	rdisciplinary team has individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program						
	B. During observa at 6:10pm, the clier to begin dinner. The meat, hard shells, stomatoes, yogurt ar #4 and client #5 se shell, one soft shell lettuce, tomatoes, youice and water. The prompts Staff D to food. Staff D goes is rocker knives and of HM cuts client #4's Record review on 1 Behavior Inventory reveals client #4 so uses knife for cutting provided by the factindependence and	is not met as evidenced by: tions in the home on 10/17/22 ats sat at the dining room table e clients were served taco soft shells, lettuce, diced and grapes family style. Client rived themselves one hard and, one scoop of meat per taco, rogurt, whole grapes, milk, e home manager (HM) cut up client #4 and client #5's into the kitchen and gets two cuts client #5's food while the food. 0/18/22 of Client #4's Adaptive completed for the 2022 year ored a level 4 in the area of ing. According to the ABI scale fility, a level 4 is total self-initiation of the task.						

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		34G090	B. WING		l l	18/2022
	PROVIDER OR SUPPLIER C OAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 907 OAKDALE AVE NEW BERN, NC 28560		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 249	level 4 for total indea knife for cutting. Interview on 10/18/#4 and client #5 are own food. However behind them to ma appropriate size. Interview on 10/18/ICF revealed if a client ABI of cutting is that the client wo The Director of ICF #5 are both capabl Based on observatinterviews, the facil received a continuous consisting of needed to support the achidentified in the Indithe areas of commiguidelines, and self audit clients (#3, A. During observation from 4:00pm - 6:306:30am - 8:30am, sto communicate with encourage client #3 Review on 10/17/2 that client #3 coming gestures and manueline encouraged to use signs/pointing/gest	Inventory revealed he scored a ependence in the area of using 22 with staff D revealed client be both capable of cutting their r, staff may have to check ke sure foods are cut to 22 with the facility's Director of ient is capable, according to their own food the expectation ould be encouraged to do so. 5 confirmed client #4 and client e of cutting food with a knife. ions, record review, and lity failed to ensure clients ous active treatment program ed interventions and services evement of objectives ividual Program Plan (IPP) in unication skills, dietary 6 f-help skills. This affected 3 of #4, and #5). The findings are: ions in the home on 10/17/22 ppm, and on 10/18/22 from staff did not use sign language th client #3, nor did staff 3 to use sign language. 2 of client #3's IPP revealed nunicates wants/needs using ual signs. He should also be	W 249			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED			
		34G090	B. WING		10	C / 18/2022
	PROVIDER OR SUPPLIER C OAKDALE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 907 OAKDALE AVE NEW BERN, NC 28560		110/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
W 249	should utilize manu when communicating and communicating the staff E revealed that through signing and client #3 learns man two signing pictures they had pictures for staff do in the home manual signs for contract the staff do in the home manual signs for contract that she could not enterview on 10/18/2 ICF revealed that if encouragement in hanguage and encontroughout the day. FOOD AND NUTRICFR(s): 483.480(a) Each client must rewell-balanced diet in specially-prescribed This STANDARD is Based on observatinterviews, the facility	al signs as much as possible ng with client #3. 22 at the day program with at client #3 communicates I pointing. When asked how mual signs, Staff E referred to son the wall and stated that or client #3. When asked what it to encourage client #3 to use immunication, Staff E stated explain what they do. 22 with the facility Director of client #3 had sign language his plan, staff should use sign urage client #3 to use signing TION SERVICES (1) ceive a nourishing, including modified and	W 2	49		
	6:10pm, the clients begin dinner. The c hard shells, soft she yogurt and grapes f	s in the home on 10/17/22 at sat at the dining room table to lients were served taco meat, ells, lettuce, diced tomatoes, amily style. Client #5 served nell, one soft shell, one scoop				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		1, ,	(X3) DATE SURVEY COMPLETED C 10/18/2022	
		34G090			10		
NAME OF PROVIDER OR SUPPLIER LIFE, INC OAKDALE HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 907 OAKDALE AVE NEW BERN, NC 28560	1 10	110/2022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE DATE		
W 460	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 4	PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP			