STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G330	A. BUILDING _____ B. WING _____	08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC CHOWAN GROUP HOME	249 COKE AVE EDENTON, NC 27932

(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 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 #5's inappropriate behavior was included in a formal active treatment program. This affected 1 of 4 audit clients. The finding is: During observations in the home throughout the survey on 8/14 - 8/15/23, client #5's grooming bin, containing her toothpaste, toothbrush, and other grooming items, was kept locked in a supply closet in the home. Various staff were observed using a key to unlock the supply closet and obtain items. Interview on 8/15/23 with Staff D and Staff F revealed client #5's grooming items are kept locked in the supply closet because she will take her toothpaste and smear it everywhere. Additional interview indicated only staff working at the home have access to the locked supply closet. Review on 8/15/23 of client #5's Behavior Intervention Plan (BIP) dated 10/15/21 revealed an objective to address behaviors of verbal agitation, property abuse, aggression and self-abuse (SIB). Additional review of the BIP did not include locking away client #5's grooming items to address her inappropriate behaviors. Interview on 8/15/23 with the Habilitation Coordinator (HC) confirmed client #5's grooming	W 288		

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

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W 288	Continued From page 1 bin was kept locked in the supply closet due to her inappropriate behaviors; however, this was not included in her BIP.	W 288		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, document review and interviews, the facility failed to ensure all staff were sufficiently trained on the appropriate use of latex gloves while working in the home. The findings are: A. During lunch observations in the home on 8/14/23 at 11:31am, Staff A and Staff C washed their hands and immediately applied latex gloves before assisting clients at the table with the lunch meal. The staff continued to wear the gloves while seated at the table during the meal. At 11:51am, Staff C wiped a client's mouth then continued to interact with another client without removing or changing the gloves. B. During evening observations in the home on 8/14/23 at 3:40pm, Staff B wore latex gloves while preparing a snack in the kitchen. The staff continued to wear the same gloves while assisting clients with serving themselves their snack at 3:48pm. At 3:50pm, Staff B was still wearing the gloves as she wiped a client's mouth at the table. Staff B removed the gloves after performing cleaning tasks in the kitchen at	W 340		

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W 340	Continued From page 2	W 340		

3:58pm. Staff E was also at the table and was not wearing gloves.

C. During evening observations in the home on 8/14/23 from 4:48pm - 5:23pm, Staff B wore latex gloves while performing meal preparation tasks. The staff continued to wear the same single pair of gloves while cracking eggs, placing slices of uncooked ham on a pan, touching knobs, stirring food on the stove, touching various surfaces and handling containers from the pantry and drawers. At 5:23pm, the staff removed the latex gloves. At 5:30pm, during the dinner meal, Staff B wore latex gloves again while assisting the clients at the table. Staff E was also at the table and did not wear latex gloves.

D. During morning observations in the home on 8/15/23 from 7:03am - 7:22am, Staff C wore a single pair of latex gloves while assisting clients with meal preparation tasks. The staff consistently manipulated various objects, knobs, surfaces without changing the gloves. During additional observations at the breakfast meal beginning at 7:48am, Staff C and Staff F wore latex gloves while assisting clients to serve themselves and while seated next to clients during the meal.

Observation on 8/14/23 of a note posted in the kitchen of the home indicated, "STAFF ARE TO WEAR GLOVES" during various situations. The note indicated, for example, gloves would be worn during certain hygiene tasks, contact with blood or bodily fluids, applying topical medications, feeding clients when in contact with saliva, and other situations. The note did not indicate, however, gloves would need to be worn during meal preparation or at the table during

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W 340	Continued From page 3 meals. Interview on 8/15/23 with Staff C revealed she had been trained to wear latex gloves in the kitchen for meal preparation and at meals when serving foods for "sanitary reasons". Additional interview also indicated staff follow what is listed on the note posted in the kitchen. Interview on 8/15/23 with the Habilitation Coordinator (HC) indicated latex gloves only need to be worn in the kitchen when the handling of raw meats is necessary. Additional interview confirmed staff should be following the guidelines on the note posted in the kitchen.	W 340		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #5's crisis medication was administered in accordance with physician's orders. This affected 1 of 4 audit clients. The finding is: During evening observations in the home on 8/14/23 from 4:08pm - 4:32pm, client #5 sat in her room while other clients were in the living room at the table with leisure activities. During this time, the client yelled out at least twice and on at least two other occasions a banging noise was heard coming from the bedroom. At 4:30pm, the Habilitation Coordinator (HC) entered client #5's bedroom and asked her what was wrong. At 4:32pm, the HS left the client's bedroom and	W 368		

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W 368	Continued From page 4	W 368		

called the nurse to obtain a crisis medication for client #5. At 4:35pm, Staff B was asked to give client #5 Ativan 1mg for her crisis medication. Prior to administration of the medication no staff were observed to interact with client #5 to address her sporadic behaviors in her bedroom.

Immediate interview with Staff B (Medication Technician) revealed client #5 had received the Ativan because she will throw things and yell so the nurse was called and she had given them permission to administer the crisis drug.

Review on 8/15/23 of client #5's physician's orders dated 8/1/23 revealed an order for Ativan 1mg. The order noted, "...take 1 tablet by mouth for behaviors not controlled by BIP (greater than) 5 minutes..."

Additional review of client #5's BIP dated 10/15/21 revealed an objective to reduce the frequency of defined agitated behavior episodes to 0 per month for 8 consecutive months. The plan included target behaviors of verbal agitation, property abuse, aggression and self-abuse (SIB). The BIP indicated several consequences to be implemented when target behaviors occurred and before use of her crisis medication including verbal prompts to stop, physically guiding her hands to her lap for 2 to 3 seconds, redirection to an activity, escorting her away from others, simple correction (i.e. picking up items thrown) and physical restraint.

Further review of the BIP noted under Emergency Drug Use, "If [Client #5] fails to calm down and her behavior episode continues for 5 minutes or greater following the implementation of [behavior plan] procedures and such behaviors are viewed

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W 368	Continued From page 5 as disruptive, as well as posing a risk for the safety of [Client #5], peers or staff, the Management staff responsible for [Client #5] will be contacted...If the QP, Habilitation Coordinator, or person in charge agrees that [Client #5] is still very disruptive and at risk for injury to self or others, the order for Ativan will be given meeting prescription order (after 5 minutes of agitation) with approval from the nurse." Interview on 8/15/23 with the HC revealed the nurse was called for the crisis medication due to client #5 throwing items all over her bedroom. The HC acknowledged the BIP interventions should be implemented prior to administration of the crisis medication. Interview on 8/15/23 with the facility's nurse revealed she had given permission for staff to give client #5 her crisis medication. The nurse confirmed the order indicates the client's BIP interventions should be implemented prior to administration of the her Ativan as noted on the physician's order.	W 368		