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

PRINTED: 11/08/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		34G326	B. WING		11/	11/07/2023	
NAME OF PROVIDER OR SUPPLIER LIFE, INC TWIN ACRES GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 2767 WILDCAT ROAD WILLIAMSTON, NC 27892			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 130	CFR(s): 483.420(a) The facility must en Therefore, the facilit treatment and care This STANDARD is Based on observatinterviews, the facilit 1 of 4 audit clients (During observations 5:54am, client #3 whedrooms' open do Further observations standing next to clie observations reveal bedroom and walking across the hallway. Client #3 then left had into the bathroom clothes. At 6am clie bathroom and went Client #3 then took her while staff A was this time client #3's open. The door was walked by and closed During an interview that client #3 owns wear it. Staff B was a goal on how to we Further interview releaves her bedroom clothes on, staff new holding either a tow Review on 11/7/23 and the facility of the fac	sure the rights of all clients. Ity must ensure privacy during of personal needs. It is not met as evidenced by: sions, record reviews and ity failed to ensure privacy for (#3). The finding is: Is in the home on 11/7/23 at reas observed standing in her orway without any clothes on. Its revealed Staff A was ent #3. Additional led Staff A exiting client #3's ing into a bathroom which is from client #3's bedroom. It is bedroom and followed Staff at; while still not wearing any ent #3 came out of the into her bedroom with Staff A. off the towel she had around is standing next to her. During bedroom door remained is not closed until Staff B.	W 1	30			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6)							

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

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.

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W 130	require assistance personal care. This verbalizations and in prompting me to clobedroomHoweve needed ay times. I or exit my room parget attention. In growe discuss various hopes I will improve further stated, "Levensure privacy: I redoor to the bedroor Staff must monitor." During an interview Intellectual Disabilit client #3 does not her privacy needs.	to ensure my privacy during is is usually done through redirection of staff asking or ose the door to my r, physical prompting will be will often leavedoors open rially clothed in an attempt to oup discussion in the home, topics related to such in e in this area". Client #3's IPP el of Assistance needed to equire monitoring to ensure the mare closed for privacy.	W 1:	30				