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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G326	A. BUILDING _____ B. WING _____	C 07/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC TWIN ACRES GROUP HOME	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A complaint survey was completed on July 24, 2023 for intake #NC00203636. The complaint was unsubstantiated. However, a deficiency was cited related to the allegation.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure that management was notified immediately of an allegation of mistreatment, neglect, or abuse. This affected 1 of 1 audited client (#1). The finding is: Review on 7/24/23 of facility's records did not reveal an investigation or incident report regarding client #1's food being withheld. Interview on 7/24/23 with staff B revealed that she was aware of an incident with client #1 refusing to come back to the breakfast table and not eating that morning. Staff B reports the incident happened 3 or 4 weeks ago and does not recall the date. Staff B did not report the incident to the management of the home because she didn't think she had done anything wrong. When client #1 refused to return to the table, her food was still available to her. Staff B reports she documented the incident however the behavior documentation did not reveal the incident in the months of June or July 2023.	W 153	W153: The facility will ensure that all allegations of mistreatment, neglect or abuse are investigated immediately as well as ensure that staff are aware of reporting protocol. Incident will be investigated per protocol and reported to appropriate authorities. All future incidents will be investigated promptly and immediately. Staff will receive training as to the proper notification requirements as it relates to client abuse, neglect, mistreatment or rights restrictions. A review of all BIP's will also be conducted. QPI, LPN., Habilitation Manager and Day Program Manager will monitor interaction and implementation at least 3 times monthly to ensure future compliance with this regulation. A record of this monitoring will be recorded on an observation form Monitoring will occur monthly by the QP and quarterly during the QA/QI audit process to ensure all investigations are conducted properly	9-22-2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 8/2/23

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 153	Continued From page 1 Interview 7/24/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed he was unaware of any incident with food being taken away or withheld from any clients of the home. Interview on 7/24/23 with the Home Manager revealed she was not aware of any incidents with food being withheld from any clients at the group home.	W 153		