STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G234	A. BUILDING _____ B. WING _____	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC LOCKWOOD STREET GROUP HOME	156 COUNTRYSIDE ROAD SW SUPPLY, NC 28462

(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 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 4 audit clients (#1) received a continuous active treatment program consisting of needed interventions and services identified in the Individual Program Plan (IPP) in the area of adaptive equipment. The finding is: During morning observations in the home on 5/21/24 at 6:35am, Staff A was observed pushing client #1 in a portable wheelchair. Further observations revealed Staff A pushing the wheelchair to the end of the dining room table. Client #1 then stood up, walked five to six steps and then sat down in a dining room chair. Additional observations revealed client #1 did not have on her gait belt. Review on 5/21/24 of client #1's Individual Program Plan (IPP) dated 1/13/24 stated, "I utilize a gait belt. This should be used for staff to assist with ambulation". Further review revealed client #1 has a gait belt is listed as adaptive equipment. During an interview on 5/21/24, Staff B stated	W 249		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G234	A. BUILDING _____ B. WING _____	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC LOCKWOOD STREET GROUP HOME	**156 COUNTRYSIDE ROAD SW SUPPLY, NC 28462**

(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 249	Continued From page 1 client #1's gait belt should be put on after her clothes are put on in the morning. During an interview on 5/21/24, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 should have had on her gait belt. Further interview revealed Staff A has not been trained in the usage of client #1's gait belt.	W 249		