

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2024
NAME OF PROVIDER OR SUPPLIER LIFE, INC LOCKWOOD STREET GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1)</p> <p>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.</p> <p>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:</p> <p>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.</p> <p>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.</p> <p>During an interview on 5/21/24, Staff B stated</p>	W 249			

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

TITLE

(X6) 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.

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

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FORM APPROVED
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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			