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

PRINTED: 06/05/2024 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	
		34G235	B. WING			06/04/2024	
NAME OF PROVIDER OR SUPPLIER  LIFE, INC FOLLY STREET GROUP HOME				6	TREET ADDRESS, CITY, STATE, ZIP CODE 5 FOLLY STREET SW UPPLY, NC 28462		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 130	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		W 1				
L ABORATOR\		DER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		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.

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		34G235	B. WING			06	/04/2024
NAME OF PROVIDER OR SUPPLIER  LIFE, INC FOLLY STREET GROUP HOME				65 F	EET ADDRESS, CITY, STATE, ZIP CODE FOLLY STREET SW PPLY, NC 28462		
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W 249	each client must interventions and and frequency to	page 1 nt's individual program plan, receive a continuous active m consisting of needed services in sufficient number support the achievement of the ed in the individual program	W 2	249			
	Based on observenterviews, the factoris (#3) receive treatment programmer interventions and	is not met as evidenced by: rations, record review and cility failed to ensure 1 of 4 audit red a continuous active in consisting of needed services as identified in the im Plan (IPP) in the areas of the finding is:					
	6/3/24 at 5:41pm, after using the toi Both the Qualified Professional (QID did she wash her wash her hands.	bservations in the home on client #3 exited the bathroom let, without washing her hands. Intellectual Disabilities DP) and Staff B asked client #3 hands; without redirecting her to Client #3 walked past both the and went to the dining room					
	#3 needs to be ve	ew on 6/4/24, Staff A stated client erbally prompted or given her hands after using the					
		of client #3's Individual P) dated 10/19/23 stated, vash my hands".					
	Review on 6/4/24	of client #3's Skills Assessment					

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AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED	
	34G235		B. WING			06/04/2024	
NAME OF PROVIDER OR SUPPLIER  LIFE, INC FOLLY STREET GROUP HOME				65	REET ADDRESS, CITY, STATE, ZIP CODE FOLLY STREET SW JPPLY, NC 28462	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 249	Continued From page 2 dated 10/2/24 revealed she is totally independent with washing her hands after using the toilet.		W 2	249			
W 454	client #3 can indepertoileting. INFECTION CONT CFR(s): 483.470(I)(	(1)	W 4	.54			
		ovide a sanitary environment nd transmission of infections.					
	Based on observat interviews the facilit infection control pro order to promote cli possible cross-cont	s not met as evidenced by: tions, record review and ty failed to ensure proper ocedures were followed in tient health/safety and prevent tamination. This potentially ants (#1, #2, #3, #4 and #5) The finding is:					
	6/3/24 at 5:41pm, cafter using the toile Both the Qualified I Professional (QIDP did she wash her hawash her hands. CQIDP and Staff B a table, sat down and utensils; serving he observations reveal	led the other four clients also gutensils, when they began					
		on 6/4/24, Staff A stated client pally prompted or given					

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W 454	gestures to wash his bathroom.  Review on 6/4/24 or Program Plan (IPP) "remind me to wash and the series of the	er hands after using the f client #3's Individual ) dated 10/19/23 stated,	W 4	54				