STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G034	A. BUILDING _____ B. WING _____	C 07/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC. WALNUT STREET GROUP HOME	**1011 EAST WALNUT STREET GOLDSBORO, NC 27530**

(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 recertification and complaint survey was competed on July 8 - 9, 2024 for Intake #NC00217620. The allegations for the complaint were unsubstantiated. However, deficiencies were cited in relation to the complaint and as a result of the recertification.	W 000		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that privacy was maintained for 1 of 4 audit clients (#2). The finding is: During observations in the home on 7/9/24 at 8:02am, Staff D was observed from a hallway in the home to administer medications in the staff office and medication area with the door completely open and others present int he room. Staff D prompted client #2 to raise her shirt and then administered insulin into client #2's abdomen. Client #2's peer, client #3, sat on the floor in the medication room and watched. Two additional staff were also in the room. No staff prompted client #3 to exit the room for medication administration privacy, and no one prompted client #2 to go to her room to ensure privacy for medication administration. Review on 7/9/24 of the facility medication administration policy revealed doors should be closed for medication administration, and clients should be assured of privacy during medication	W 130		

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

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W 130	Continued From page 1 administration. Interview on 7/9/24 with facility nurse A revealed staff should have taken client #2 to her bedroom for medication administration for privacy or asked everyone to leave the medication room during administration. In addition, the door should be closed. Interview on 7/9/24 with facility nurse B revealed staff should always ensure privacy when administering medications.	W 130		
W 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on observations, record reviews and interview, the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to ensure the active treatment program for 1 of 4 audit clients (#4) was coordinated and monitored as needed. The finding is: Observation throughout 7/8/24 to 7/9/24 at the day program and home revealed client #4 in her wheelchair with a gait belt on and soft helmet. Staff were observed to assist client #4 to transfer to/from wheelchair by using the gait belt and transferring without locking the wheelchair. Client #4 attempted to move about the home by self-propelling her wheelchair with her feet. Review on 7/9/24 of client #4's individual program plan (IPP), dated 5/16/24, revealed she is a falls risk, but should use the wheelchair to move about	W 159		

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W 159	Continued From page 2 the home independently due to drop seizures. In addition, she is unsteady when walking, so staff use a gait belt for assistance on unleveled surfaces and getting on/off the van. No wheelchair or ambulation guidelines were available. Review of client #4's most recent physical therapy evaluation, dated 10/25/16, revealed she had increased unsteadiness in ambulation. She transfers and is capable of ambulating short distances within her living environment without an assistive device, but needs close contact supervision. Due to being in a wheelchair for extended time following a fracture, her ambulation decreased. She appears to prefer a wheelchair and needs considerable verbal cueing to ambulate. She presently has a gait belt which can be used by staff to assist her during periods of instability or getting off of van. The wheelchair was recommended for the period of instability. No gait belt or ambulation guidelines were available. Interview on 7/9/24 with the qualified intellectual disabilities professional (QIDP) revealed client #4 did not have an updated physical therapy evaluation with guidelines for client #4's gait belt/wheelchair needs. However, the QIDP acknowledged client #4's mobility had somewhat changed since the last physical therapy evaluation and may need to be re-evaluated.	W 159		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189		

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W 189	Continued From page 3	W 189		

This STANDARD is not met as evidenced by:
Based on observations, record review, and interviews, the facility failed to ensure staff were sufficiently trained in gait belt use and wheelchair transfer for 1 of 4 audit clients (#4). The finding is:

Observations in the home and day program throughout 7/8/24 - 7/9/24 revealed client #4 wearing a gait belt and in a wheelchair as she used her feet to propel the chair in her environment. Staff were observed to assist her in transferring to/from the wheelchair to other chairs by using her gait belt as she stood, pivoted, and sat. Staff did not lock the wheelchair when transferring and using the gait belt. In addition, staff inconsistently assisted client #4 in pushing her wheelchair. At times, she moved about independently, and at other times, staff pushed her chair.

Review on 7/9/24 of client #4's individual program plan (IPP), dated 5/16/24, revealed she is a falls risk and uses a wheelchair to move about home independently due to drop seizures. In addition, she is unsteady when walking so staff use a gait belt for assistance on unleveled surfaces and getting on/off the van. No wheelchair or ambulation guidelines were available.

Review of client #4's physical therapy evaluation, dated 10/25/16, (eight years ago) revealed she had increased unsteadiness. She transfers and is capable of ambulating short distances within her living environment without an assistive device, but needs close contact supervision. Due to being in a wheelchair for extended time following a fracture, her ambulation decompensating. She appears to prefer a wheelchair and needs considerable verbal cueing to ambulate. She

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W 189	Continued From page 4 presently has a gait belt which can be used by staff to assist her during periods of instability or getting off of van. The wheelchair was recommended for the period of instability. No gait belt or ambulation guidelines were available. Review on 7/8/24 of the facility incident report for client #4 on 5/18/24 revealed she had fallen while being assisted to her wheelchair. On 5/20/24, the client was seen holding her left arm. Staff reported the sighting to the nurse, and client #4 was taken to urgent care, where she was treated for a fractured wrist. A facility investigation was completed. Although video footage could not conclude the previous fall had resulted in the fracture, the facility stated all staff were inserviced on the proper way to assist client #4 to and from her wheelchair. Review on 7/9/24 of inservice documentation revealed no inservice for staff training on gait belt/wheelchair use in relation to the investigation. In addition, no guidelines could be located. Interview on 7/9/24 with the qualified intellectual disabilities professional (QIDP) revealed the former home supervisor had inserviced staff on the gait belt and transferring from the wheelchair, but she could not produce the inservice sheet. Interview on 7/9/24 with facility nurse A confirmed staff should be trained on updated guidelines for client #4's gait belt/wheelchair use.	W 189		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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W 249	Continued From page 5 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 each client received a continuous active treatment program consisting of needed interventions and services and identified in the Individual Program Plan (IPP) and Behavior Intervention Plan (BIP). This affected 1 of 4 audit clients (#3). The finding is: During morning observations on 7/10/24 at 6:50am in the home, client #3 was overheard in the hallway crying and yelling out loudly. Staff attempted to calm her and have her join in the den activities. From 7:55am to 8:25am, client #3 sat or laid on the floor of the medication room/staff office. At 8:00am, Staff F offered a verbal prompt for her to get up from the floor. Client #3 continued to lay on the floor during medication administration to her peers and blocking staff from moving in and out of the room at times. She continued to lay face down, with her arms folded and banged her head on her arms. At 8:03am, client #3's assigned 1:1 staff arrived to work at the home. At 8:08am, the client #3 continued to lay face down on the medication room floor/staff office, banging her head on her arms. At no time did staff offer physical prompting for redirection. Review of client #3's IPP, dated 9/12/23, revealed	W 249		

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W 249	Continued From page 6 she has a dark calloused area on forehead from banging head and receives support from a 1:1 staff to aid in assisting with routine schedules and interactions within home. Review of client #3's BIP, dated 12/22/23, revealed target behaviors to include defiance, stealing, aggression, self-inflicted injury, and PICA. She has a 1:1 staff at designated times of the day. Client #3 prefers to be on the floor and may remain on the floor for long periods of time, despite redirections from staff. If she is blocking access to other areas of the house, staff should physically prompt her to get off the floor. If she refuses after 4 or 5 requests, staff should assist her in getting off the floor by using physical assistance. Interview on 7/9/24 with Staff A revealed client #3 has a 1:1 staff assigned to her during the day, but not on second shift. If she is blocking access, they can offer verbal or physical prompting for her to move. Interview on 7/10/24 with the qualified intellectual disabilities professional (QIDP) revealed client #3 has a 1:1 staff from 8:00am to 4:00pm. The staff should be "right with her". The facility has been looking into extending the 1:1 hours to cover early morning as well. The QIDP confirmed the 1:1 staff should be visual/close proximity to client #3 and should offer verbal/physical prompting if necessary.	W 249		
W 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) Nursing services must include implementing with other members of the interdisciplinary team,	W 342		

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W 342	Continued From page 7	W 342		

appropriate protective and preventive health measures that include, but are not limited to training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.
This STANDARD is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure staff were sufficiently trained in reporting medical concerns. This affected 1 of 4 audit clients (#4). The finding is:

Review on 7/8/24 of the North Carolina Incident Response Improvement System (IRIS) report, dated 5/20/24, revealed Staff A noticed client #4 holding her left arm prior to leaving for the day program that morning. Staff A said she had been holding it off and on during the earlier part of the morning. Nurse A was notified, and staff transported client #4 to urgent care. It was determined by x-ray that her left wrist was fractured, and she received a cast on her arm. The report stated client #4 fell on the weekend but it was unknown if this is what caused the fracture. Management noted that an incident report had been completed for client #4 on 5/18/24 after a fall. Further review revealed preventative measures for future incidents included closer monitoring and additional assistance as needed when transferring client #4 from a regular chair to her wheelchair. Staff should complete a thorough body check after incidents and follow proper procedures for reporting any injuries.

Review of an incident report, dated 5/18/24, revealed Staff A assisted client #4 from a chair to her wheelchair with the use of her gait belt when she slid down, falling to the floor. Nurse A was

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notified by phone, and client #4 was checked for injuries by direct care staff on 5/18/24. No injuries were noted.

Review on 7/8/24 of the facility formal inquiry form, no date signed, revealed a completed incident report for client #4 on 5/18/24 after she had fallen while being assisted to her wheelchair by Staff A. On 5/20/24, the client was seen holding her left arm, and staff reported to facility nurse A. Client #4 was taken to urgent care by staff after being directed by Nurse A. X-rays revealed she had a fractured wrist. The facility interviewed six staff members and obtained confidential statements to determine if the fall resulted in the fracture. In addition, the facility viewed video footage and and could not determine that the fall would have caused the fracture. Review of staff written statements revealed Staff A and B's seemed "disoriented" and "not herself" immediately after the fall. However, the remaining staff revealed client #4 "seemed fine" and exhibited no symptoms of discomfort or pain during the weekend.

Interview on 7/9/24 with the qualified intellectual disabilities professional (QIDP) revealed the video was viewed but they could not determine that client #4 had broken her wrist during the accident because the staff noted no complaints during the weekend. On video, the staff utilized the gait belt for transfer, but client #4 slid down in front of the couch to the floor as a fall. The staff noticed she was complaining on Monday, but reported she seemed fine over the weekend and during personal care. The QIDP confirmed the nurse comes to the home on weekends if it is determined to be needed after speaking with direct care staff. The QIDP confirmed direct staff

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W 342	Continued From page 9 were not medically trained to assess injury. Interview on 7/9/24 with nurse A revealed she received a call on 5/18/24 that client #4 had slid down and fallen off of the couch during transfer. She completed triage over the phone for client #4 as staff examined her. The staff did not convey that she had visible injury or that she was in pain. Nurse A told them to give her Tylenol and monitor. Nurse A called the home on Sunday to check on client #4, and staff again stated she seemed fine, had completed personal care independently, and was not complaining. Early morning on 5/20/24, she was notified that client #4 was holding her wrist and pointing to show it was hurting. When asked what happens on the weekend if a client is hurt, the nurse stated she can view video or complete triage with staff to determine further action needed. The nurse stated staff A and B never told her client #4 seemed disoriented or not acting like herself immediately after the fall. However, she confirmed that staff should have known to communicate symptoms and needed to be trained how to recognize symptoms during first aid and emergency assessments.	W 342		