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		IDENTIFICATION NUMBER.		2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		34G235			06/04/2024		
NAME OF PROVIDER OR SUPPLIER LIFE, INC FOLLY STREET GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 65 FOLLY STREET SW SUPPLY, NC 28462			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETION DATE	
	CFR(s): 483.420(a) The facility must et Therefore, the facility reason treatment and care This STANDARD Based on observation interviews, the facility of 4 audit clients During evening observations of 4 audit clients During evening observation of 4 audit clients During an interview #3 will sometimes independently for program Plan (IPP regularly must removed and 10/2/23 stated oor for privacy is During an interview Intellectual Disability revealed client #3 to shut the bathrood PROGRAM IMPLE CFR(s): 483.440(c)	Insure the rights of all clients. Ility must ensure privacy during a of personal needs. It is not met as evidenced by: It itions, record reviews and lity failed to ensure privacy for (#3). The finding is: Servations in the home on client #3 entered the bathroom her pants along with her adown on the toilet. The door ille client #3 was sitting on the was client #3 prompted to shut. The door remained open for a client #3's Individual of client #3's Individual of client #3's Skills Assessment and that closing the bathroom, a need. If on 6/4/24, the Qualified ities Professional (QIDP) needs to be verbally prompted om door. EMENTATION	W 24	Facility will ensure the rights of clients by ensuring privacy dur treatment and care of personal needs. All staff will be re-in serviced or client rights specific to each clieright to privacy during personal hygiene care, dressing, and to Assessments will be reviewed/completed on each consumer to determine if training is warrants. Staff will also be re-in serviced staff responsibility in ensuring privacy for all clients. Observational and inspections will be completed the QII and Habilitation Managensure daily implementation are future compliance of this plan correction. Inspections will be completed and documented a minimum of three times month.	ring I I I I I I I I I I I I I I I I I I I	8-1-20 24	
	V DIDECTORIS OF PROV	IDED/CLIDDLIED DEDDESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

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

Susan Ayers

Director of ICF

Facility ID: 921857

6-17-2024

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

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				STREET ADDRESS, CITY, STATE, ZIP CO 65 FOLLY STREET SW SUPPLY, NC 28462			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
W 249	each client must a treatment prograr interventions and and frequency to objectives identification. This STANDARD Based on observinterviews, the factients (#3) receivinterviews, the factients (#3) receivinterventions and Individual Program hand washing. The During evening of 6/3/24 at 5:41pm, after using the toil Both the Qualified Professional (QID did she wash her wash her hands. QIDP and Staff Bitable. During an interview #3 needs to be very gestures to wash bathroom. Review on 6/4/24 Program Plan (IF "remind me to very standard program and the program of the pr	at's individual program plan, receive a continuous active in consisting of needed services in sufficient number support the achievement of the ed in the individual program is not met as evidenced by: retions, record review and cility failed to ensure 1 of 4 audit red a continuous active in consisting of needed services as identified in the in Plan (IPP) in the areas of the finding is: poservations in the home on client #3 exited the bathroom let, without washing her hands. Intellectual Disabilities of hands; without redirecting her to Client #3 walked past both the and went to the dining room ew on 6/4/24, Staff A stated client erbally prompted or given her hands after using the		249- Facility managers will er client receives a continuous a treatment program including I to needed interventions and s sufficient numbers and freque pertains behavior manageme implementing toileting prograthe achievement of the object identified in the IPP. All BIP's reviewed as well as the IPP r toileting programs/handwash changes deemed necessary will be made and addendums added to the My Life Plan. A in-serviced on all behavioral include any updates made, for as it pertains to interventions toileting programs and needefor essential tasks or interver clients. On-going monitoring consistent while in the home than bi-weekly to ensure com this area. Documentation on will occur on LIFE Inc's facilit form, employee observation is schedules as applicable and documentation.	active but not limited services in ency as it ent and ms to support tives as swill be elative to ing. Any by the team swill be all staff will be programs to or all clients in regards to ed intervention tions for all gwill be but no less apliance in monitoring y inspection logs, toileting	8-1-2024	

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 06/04/2024	
		34G235		B. WING				
	PROVIDER OR SUPPLIE			65 F	EET ADDRESS, CITY, STATE, ZIP CODE OLLY STREET SW PLY, NC 28462			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
W 249	with washing her During an intervic client #3 can inder toileting. INFECTION COI CFR(s): 483.470 The facility must to avoid sources This STANDARD Based on observinterviews the faci infection control order to promote possible cross-co affected all the cliving in the home During evening of 6/3/24 at 5:41pm after using the to Both the Qualifie Professional (QII did she wash her wash her hands. QIDP and Staff E table, sat down a utensils; serving observations rev	vealed she is totally independent hands after using the toilet. ew on 6/4/24, the QIDP stated ependently wash her hands after NTROL (I)(1) provide a sanitary environment and transmission of infections. is not met as evidenced by: vations, record review and cility failed to ensure proper procedures were followed in client health/safety and prevent contamination. This potentially lients (#1, #2, #3, #4 and #5) e. The finding is: observations in the home on a client hands without washing her hands. In the lectual Disabilities of the lectual Disabilities o	W		W454- The facility will enemployees receive training ensure a sanitary environs avoid sources and transminfections. Facility management that sanitizing against the sanitizing and the sanitizing the sanitation and effectively in a timely using approved sanitation and effectively in a timely using approved sanitation and effectively in a timely using approved sanitation. All staff will receive update regarding BBP and compited as proper hygiene to cross contamination. This correction will be monitor QP/HC/Nurse on an ongoth through scheduled inspection in the FIDs arandom inspections.	ng to nment to nissions of gers will ents be oughout the . Staff will all sanitary ved includes, g that all led properly y manner in protocol. ted training oliance as o prevent is plan of red by the oing basis ctions a onth and	8-1-2024	
		ew on 6/4/24, Staff A stated client erbally prompted or given						

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:	The state of the s	RIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		34G235	B. WING		06/04/2024			
NAME OF PROVIDER OR SUPPLIER LIFE, INC FOLLY STREET GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP C 65 FOLLY STREET SW SUPPLY, NC 28462		00/07/2027		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
W 454	gestures to wash h bathroom. Review on 6/4/24 of Program Plan (IPP "remind me to was Review on 6/4/24 of dated 10/2/24 revewith washing her had During an interview	er hands after using the f client #3's Individual) dated 10/19/23 stated,	W 4	54				

Event ID: CNJJ11