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

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 07/30/2024

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 complaint survey was completed on 7/30/24. Intake #NC00219994 was substantiated. Intakes #NC00219971 and #NC00219915 were unsubstantiated. Deficiencies were cited.	W 000		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to assure the administrator was notified immediately of incidents that may require investigation. This affected 2 of 6 clients (#3 and #6) in the home. The finding is: Interview on 7/30/24 with Staff B revealed she works with Staff F on second shift regularly. Staff B acknowledged staff may talk firmly to clients at times, but Staff F talks too firmly. Staff B stated Staff F told her she was caught on camera for pushing a client and had been called into administration. When asked if she was aware of clients' personal items being taken away as punishment, Staff B revealed Staff E had been told Staff F had taken client #6's purse away and put it in her car, after also telling client #6 she was taking her purse as punishment. Staff F left work with the purse. In addition, client #6 had cried all night afterwards. When asked if she had reported the incident to administration, Staff B revealed she had not, but she knew she should have reported the incidents.	W 153		

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.

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Interview on 7/30/24 with Staff C revealed she worked on second shift and had heard Staff F often yell at the clients in the home. She was aware that Staff F had taken client #6's purse from her as punishment when she tears paper. If she gets paper on the floor, Staff F yells at client #6. Staff C has not observed any staff being physically abusive toward clients. However, she witnessed Staff F yell at client #4 after she had a seizure because she would not get up from the floor fast enough. In addition, she has seen Staff F punish client #3 by making her be last to receive her medications if client #3 stands at the medication room door. Staff C stated this upsets client #3. When asked why she had not reported the incidents, Staff C stated she knew she should report it, but she did not trust the former administration in the home as they were friends with the staff. She does know the new home manager well yet, and is not famliar with the interim Qualified Intellectual Disabilities Professional (QIDP).

Interview on 7/30/24 with Staff D revealed she worked on second shift. Staff D confirmed client #6 was upset one day because her purse was taken, but she did not see what happened. Staff E reported to her that Staff F had taken client #6's purse as behavior management, but it was not in her plan to take the purse. When asked why she did not report it, she stated she did not see it happen.

Interview on 7/30/24 with Staff E revealed she works third shift. She is aware that Staff F has taken client #6's purse more than once, and client #6 cries because her purse was taken. Staff E revealed she did not know if this was part of client

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W 153	Continued From page 2 #6's behavior plan, but it was like a punishment. Staff F told client #6 she was putting her purse in her car, and client #6 was up all night crying because to it. Staff E did report the incident to the former home manager and QIDP that are no longer at the home. Nothing was done. Interview on 7/30/24 with Staff F revealed she is not aware of anyone talking harshly to clients or taking items from clients for punishment. Staff F stated she would report it to her supervisor if she saw this. Interview on 7/30/24 with Staff A revealed she served as the new home manager and had no knowledge of Staff F harming or talking harshly to clients, and no report had been made to her about incidents of staff mistreatment of clients. Interview on 7/30/24 with the interim QIDP revealed the previous QIDP left the home on 7/12/24, and a new QIDP begins on 8/5/24. Three incidents have been reported in July, and no reports of staff taking harshly to clients, physically abusing clients, or taking their items have been made. Interview on 7/30/24 with the Director of Intermediate Care Facilities (DICF) revealed administration had no reports of incidents of physical or verbal abuse from the home. Staff F received a negative performance evaluation on 7/10/24 after being observed through camera footage to pull on client #4's gait belt to get her into her wheelchair. She received correction through the negative evaluation. However, staff had not reported incidents of Staff F taking items from client #6 as punishment.	W 153		

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W 153	Continued From page 3 Review on 7/30/24 of the facility consumer right policy, dated 2/20/23, revealed all staff receive initial and ongoing training to promote consumer well-being and prevent abuse, neglect, and mistreatment. All rights violations will be investigated promptly with proper disciplanary measures. All staff are expected to immediately report any alleged or witnessed incidents of rights' violations and suspected abuse, neglect, or exploitation of persons served. Additional interview on 7/30/24 with the DICF revealed Staff F will be suspended immediately as the facility begins an investigation into the allegations from staff interviews. In addition, all staff will be inserviced on reporting verbal and physical abuse, client behavior plans, and ensuring access to their personal belongings.	W 153		
W 286	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to assure techniques to manage the inappropriate client behavior of 1 of 6 clients (#6) in the home was not used for disciplinary purposes. The finding is: Review on 7/30/24 of client #6's behavior intervention plan (BIP), dated 1/15/24, revealed target behaviors to include vocal agitation and crying. Staff should implement proactive, preventative procedures to intervene and help her calm. No restrictive measures were included in	W 286		

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W 286	Continued From page 4 the plan. Interview on 7/30/24 with Staff B revealed she works with Staff F on second shift regularly. Staff B revealed Staff F talks too firmly to clients and had taken client #6's purse away and put it in her car. Staff F told client #6 she was taking her purse as punishment and left work with the purse. Staff B was told client #6 cried all night. Interview on 7/30/24 with Staff C revealed she worked on second shift and had heard Staff F often yell at the clients in the home and had taken client #6's purse from her as punishment when she tore paper as a sensory activity. If she gets paper on the floor, Staff F yells at client #6. Interview on 7/30/24 with Staff D revealed she worked on second shift. Staff D confirmed client #6 was upset one day because her purse was taken, but she did not see what happened. Staff E reported to her that Staff F had taken client #6's purse as behavior management, but it was not in her behavior plan for staff to take her purse. Interview on 7/30/24 with Staff E revealed she works third shift. She is aware that Staff F has taken client #6's purse more than once, and client #6 cries because her purse was taken. Staff E revealed she did not know if this was part of client #6's behavior plan, but it was like a punishment. Staff F told client #6 she was putting her purse in her car, and client #6 was up all night crying because to it. Interview on 7/30/24 with the Staff F revealed she is not aware of anyone talking harshly to clients or taking items from clients for punishment.	W 286		

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W 286	Continued From page 5 Interview on 7/30/24 with the home manager revealed she had just started as the new home manager and had no knowledge of Staff F harming or talking harshly to clients. In addition, no report had been made to her about incidents of staff mistreatment of clients or taking items from them. Interview on 7/30/24 with the interim Qualified Intellectual Disabilities Professional (QIDP) revealed no reports of staff taking harshly to clients, physically abusing clients, or taking their items have been made. Interview on 7/30/24 with the Director of Intermediate Care Facilities (DICF) revealed administration had no reports of incidents of physical or verbal abuse from the home. Staff F received a negative performance evaluation on 7/10/24 after being observed through camera footage to pull on client #4's gait belt to get her into her wheelchair. She received correction through the negative evaluation. However, staff had not reported incidents of Staff F taking items from client #6 as punishment.	W 286		