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

PRINTED: 09/23/2025 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		
		34G205	B. WING			09/23/2025	
	PROVIDER OR SUPPLIER  DIXON ROAD GRO	UP HOME		STREET ADDRESS, CIT ROUTE 1, BOX 842-B CHOCOWINITY, NO	<b>,</b>	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CORR	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 262	CFR(s): 483.440(f)  The committee shomonitor individual properties behaving the opinion of the client protection and This STANDARD is Based on record refailed to ensure the techniques for 1 of reviewed and monicommittee (HRC).  Review on 9/22/25 Plan (BSP) revealed that stated the client placed on his bedrooked and the pan supplies would be lead to the committee of the client stated the placed on the pan supplies would be lead to the committee of the client placed on the pan supplies would be lead to the committee of the commit	ould review, approve, and programs designed to manage vior and other programs that, a committee, involve risks to d rights. Is not met as evidenced by: eview and interview, the facility a restrictive behavior 3 audit clients (#3) was tored by the human rights	W 2	62			
W 263	Interview on 9/23/2 Disabilities Profess #3 did not have HR listed on the BSP PROGRAM MONIT CFR(s): 483.440(f) The committee sho are conducted only consent of the clier minor) or legal gua This STANDARD i Based on record re	ould insure that these programs with the written informed ht, parents (if the client is a	W 2	63			(X6) DATE

(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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		34G205	B. WING _		09	/23/2025	
NAME OF PROVIDER OR SUPPLIER  LIFE, INC DIXON ROAD GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP COROUTE 1, BOX 842-B CHOCOWINITY, NC 27817			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC 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 263	conducted with the	trictive programs were only written informed consent of a affected 1 of 3 audit clients	W 20	63			
	Plan (BSP) reveale that stated the clie placed on his bedro locked and the pan supplies would be I the use of Haldol, I control behaviors.	of client #3's Behavior Support d an addendum dated 5/27/25 nt would have a door alarm from door, snacks would be try that contained cleaning ocked. The BSP also included hydroxyzine and Propranolol to					
W 289	guardian consent h Interview on 9/23/2 Disabilities Profess	ad been obtained.  5 with the Qualified Intellectual ional (QIDP) confirmed no I been obtained by the #3's BSP.  ROPRIATE CLIENT	W 2	89			
	inappropriate client incorporated into the plan, in accordance this subpart.  This STANDARD is Based on observation interviews, the facility systematic interventinappropriate behavior the client's individual.	atic interventions to manage behavior must be e client's individual program with §483.440(c)(4) and (5) of s not met as evidenced by: tions, record reviews and ity failed to ensure the use of tions to manage clients viors were incorporated into al program plan (IPP). This t clients (#2 and #5). The					

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
W 289	A. During observation the survey on 9/22/kitchen was kept look Review on 9/22/25 Plan (BSP) dated 2 restriction for the particular of the survey on 9/22/kitchen was kept look Review on 9/22/25 2/24/25 did not rever pantry to be locked Interview on 9/23/2 cabinet is locked during restriction on 9/25/2 cabinet is locked during restriction.	ons in the home throughout 25 - 9/23/25, the pantry in the cked.  of client #2's Behavior Support 1/20/25 did not reveal a rights antry to be locked.  ons in the home throughout 25 - 9/23/25, the pantry in the cked.  of client #5's BSP dated eal a rights restriction for the	W 2				