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
	34G090	A. BUILDING ______ B. WING ______	R 11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC OAKDALE HOME	**907 OAKDALE AVE NEW BERN, NC 28560**

(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 revisit was completed on 11/20/25 for deficiencies cited during the 9/16/25 - 9/17/25 survey. Two deficencies were corrected. However, three deficiencies were recited, and the facility remains out of compliance. In addition, a complaint survey was completed for Intake #NC00234263. A deficiency was cited.	W 000		
{W 226}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure each client received an Individual Program Plan (IPP) within thirty days after admission. This affected 1 of 1 newly admitted audit clients (#5). The finding is: Record review on 9/16/25 of client #5's record revealed he was admitted to the facility on 9/23/24. Further review revealed client #5 did not have an IPP. Interview on 9/16/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed the facility had been using the IPP from client #5's previous provider 9/23/24 to 8/29/25. The facility had completed his evaluations within 30 days of admission. However, objectives, based on evaluations, were not implemented until 11/4/24. The QIDP confirmed client #5 did not have an IPP within 30 days of his admission to the facility. Further interview revealed it is the QIDP's responsibility to ensure IPP's are completed for newly admitted clients.	{W 226}		

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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{W 226}	Continued From page 1 The facility plan of correction (POC), dated 10/8/25, states the QIDP will ensure the plan is completed and uploaded to Therap. Record reviews monthly should indicate the admission and alert the Regional coordinator, who will follow up within 7 days of the admission to ensure compliance and document this in Therap. Review on 11/20/25 of client #5's record revealed no evidence of an IPP. Interview on 11/20/25 with the Home Manager (HM) revealed client #5's "old plan" was used to provide services. Interview on 11/20/25 with the QIDP revealed she had completed his IPP, but she could not locate it. When asked if she had a copy of the IPP or had trained staff on the new IPP, she confirmed she could not find the IPP.	{W 226}		
{W 240}	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure client #4's Individual Program Plan (IPP) included relevant interventions to support his independence. This affected 1 out of 4 audit clients. The finding is: A. Observation in the home throughout 9/16/25 to 9/17/25 revealed client #4 wearing a gait belt and using the wall, as well as furniture, to balance as he ambulated with an unsteady gait. On 9/16/25,	{W 240}		

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{W 240}	Continued From page 2 no staff was observed using the gait belt to assist client #4 as he ambulated. On 9/17/25 at 6:45am, he entered the den area, holding onto the wall and couch, to move towards the kitchen. Staff A left the kitchen to use the gait belt and briefly assist him into the area. At 6:55am, he held to the wall to go to the dining area and be seated. At 7:10am, he attempted to carry his plate and place mat in his arms to the kitchen and lost his balance. He stopped to use the doorway to balance himself, and then proceeded to the kitchen. He then used the wall and furniture to go to the back of the home alone. Staff did not use the gait belt to assist. Review on 9/17/25 of client #4's IPP, dated 6/4/25, revealed he has mild, lower extremity spasticity with a stiff gait and cerebral palsy. While he ambulates independently, he has presented emerging problems regarding mobility. A gait belt has been recommended. No further guidelines could be located for the use of a gait belt or fall precautions. Review on 9/17/25 of client #4's physical therapy (PT) evaluation, dated 4/2/25, revealed client #4 transfers and ambulates independent of a device. However, "his gait is labored, at best", as he reaches for furniture and walls for stability. He has an increased leaning, forward gait with a bent spine. He has had no falls reported, but is at increasing risk for falls. His gait has declined significantly since 2023. A gait vest would be beneficial to enable staff better to counter his forward lean. He is a high falls risk at this time. No further guidelines were specified for the use of the gait belt. Interview on 9/17/25 with the Director of Nursing	{W 240}		

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revealed client #4 is unsteady and staff should be with him nearby at all times to assist when he ambulates. Staff should use the gait belt to assist him. It was assumed the staff knew to use the gait belt.

Interview on 9/17/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff should be using the gait belt to assist client #4 in walking. However, the QIDP confirmed there were no ambulation guidelines in place for the use of the gait belt.

The facility plan of correction (POC), dated 10/8/25, states all IPPs will describe relevant interventions needed to support the individual toward independence. The facility will ensure all equipment used is reviewed regarding it's use, and training will be completed in the use of equipment. Any changes will be made and updated in the IPP. All staff will receive additional training to address each client needs. Occupational Therapy (OT) will be contacted for reevaluation if necessary. The QIDP, Nurse, and Habilitation Manager will monitor on an ongoing basis utilizing monthly inspection forms that will consist of no less than three per month to ensure proper use and documented during observations in FIDS.

Review on 11/20/25 revealed no documented review of adaptive equipment, additional staff training, and reevaluations. In addition, no monitoring documentation was located.

Interview on 11/20/25 with the QIDP revealed there was no documentation of the corrections.

B. Review on 11/20/25 of the Incident Response

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{W 240}	Continued From page 4 Improvement System (IRIS) report, dated 10/15/25 revealed an incident on 10/4/25 at 8:15am in which client #5 displayed aggressive and sexually inappropriate behavior toward clients #3 and #4. The incident was reported to the local police department and the Department of Social Services (DSS), as well as guardians for all three clients involved. Staff A, assigned to the floor, was in the medication room with the administrator for approximately 45 minutes while clients were in the den, unsupervised. Client #5 masturbated in the den with clients #3 and #4 present. He then put sanitizer on his hands and rubbed their heads. During this time, he also jumped at them and pretended to hit them as they sat on the couch. Review on 11/20/25 of video footage from 10/4/25 revealed clients #3, #4, and #5 in the den area with no staff for 23 minutes from 8:11am - 8:26am. At 8:15am, client #5 walked over to client #4, said something and waited. When client #4 did not respond, he went to sit in the other chair. At 8:23am, he put his hands in his pants and masturbated while clients #3 and #4 sat in the den watching television. At 8:27am, he briefly pulled his pants down and up, then walked to the kitchen to use hand sanitizer. At 8:28am, he walked to client #3, opened his arms, and hugged him for 10 seconds. He sits down briefly and then goes to the back hallway area to return and approach client #3 to repeatedly rub his head for 10 seconds. At 8:33am, he approached client #4 to repeatedly rub his head for 10 seconds. The video ended at 8:36am. No staff was seen in the area for the duration of the video. Review on 11/20/25 of the facility investigation, dated 10/13/25, revealed an investigative team to	{W 240}		

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include the facility Social Worker (SW), QIDP, and the Habilitation Manager (HM). The HM was conducting a camera review when he observed the video. He immediately reported the incident after viewing on 10/13/25. Camera footage was reviewed by the team, and client #5 was interviewed. Per client #5, he waited for staff to be occupied before the incident took place. Staff were in the medication room talking during the time and he " listened out " for staff during the incident, stopping once when he thought someone was coming.

Further review of the investigation revealed the facility had given disciplinary action to Staff A for failing to adequately monitor the floor. All staff in the home were in-serviced on monitoring clients in the home.

Review on 11/20/25 of staff inservices revealed training for staff responsibilities and supervision was completed for all staff in the home in October, 2025.

Review on 11/20/25 of client #6 ' s behavior intervention plan (BIP), dated 10/21/24, revealed target behaviors to include aggression, bullying, defiance, false allegations, stealing, and verbal/gestural threats. No mention of sexually inappropriate behavior could be located.

Interview on 11/20/25 with the Home Manager revealed he has noticed client #5 is affectionate and tries to hug or touch others at times, saying that he "is trying to make friends".

Interview on 11/20/25 with the QIDP revealed the facility just happened to see the video footage a couple of weeks following the incicent. It was

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{W 240}	Continued From page 6 immediately reported, and they formed an investigative team. After speaking with client #5, he revealed that what he had done was wrong, and he was worried about being transferred. The QIDP stated this is the first time they had ever seen this behavior from him, and the team has not met on the matter to address behavioral support. No training on sex education has been planned.	{W 240}		
{W 278}	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(1)(iii) Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure less intrusive, more positive techniques were implemented prior to the use of more intrusive techniques for 1 of 4 audit clients (#1). Review on 9/16/25 of client #1's Behavior Intervention Plan (BIP), dated 8/21/25, revealed a target behavior of inappropriate social behavior, defined as rumination and repetitive talking. Repetitive talking refers to client #1 continuing to focus on a particular subject or question after three redirections. After redirecting three times, staff may use restriction as an intervention. Restriction means to lose access to personal items such as stereo, television, CDs, tapes, etc. for the remainder of the day. Furthermore, client	{W 278}		

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#1 will be excluded from any planned workshop or group home outing for the day.

Review on 9/16/25 of client #1's previous BIP, dated 8/21/23, revealed the same target behavior and restriction for intervention.

Review on 9/17/25 of client #1's behavior data from 1/1/25 to 9/17/25 revealed no documented repetitive talking behavior.

Interview on 9/16/25 with Staff B revealed he has been working in the home for the past several months and has never seen items restricted from client #1.

Interview on 9/16/25 with Staff C revealed he has been working in the home for a couple of months and has never seen items restricted from client #1. While he does tend to talk about favored subjects, he usually will stop if prompted.

Interview on 9/17/25 with the Qualified Intellectual Disabilities Professional (QIDP) revealed she has been at the home for a year and is not aware of client #1's items being restricted. He does tend to talk about certain things, but usually will stop repeating himself when prompted. The QIDP confirmed the plan should be updated as the restrictions are not used or needed.

The facility plan of correction (POC), dated 10/8/25, revealed all behavior plans will be reviewed by the team, and changes will be made as needed. Staff will be inserviced and plans implemented. Plans will be reviwed monthly in regard to rates and quarterly by the team.

Review on 11/20/25 of team reviews, staff

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{W 278}	Continued From page 8 inservices, and monitoring reviews revealed no documentation of the plan of correction by the team. Interview on 11/20/25 with the QIDP revealed she had no documentation of the team meeting, plans being updated, or staff inservicing for the behavior plans.	{W 278}		