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 03/02/2026

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

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W 000	INITIAL COMMENTS A complaint survey was completed on March 2, 2026 for inatke #NC00235859. The complaint was substantianted and a Condition of Participation in Client Protections and standard level deficiencies were cited.	W 000		
W 122	CLIENT PROTECTIONS CFR(s): 483.420(a) The facility must ensure the rights of all clients. Therefore the facility must This CONDITION is not met as evidenced by: The facility failed to: ensure all alleged violations are thoroughly investigated (W154). The cumulative effect of these systemic practices resulted in the facility's failures to provide statutory mandated services of client protections to its clients.	W 122		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to thoroughly investigate an injury of unknown origin, potential exposure to illegal substances and potential issues of misadministration of medications for 2 of 4 audit client (#4 and #6). The finding is: Review on 3/2/26 of client #6's hospital records revealed client #6 was taken to the local emergency department (ED) on 1/31/26 at 6:26am. Client #6 was unresponsive, hypothermic and hypotensive on arrival. The records revealed in the ED, client #6 was placed	W 154		

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 154	Continued From page 1	W 154		

in the Bair hugger for hypothermia, received a heated fluid bolus for hypothermia and concerns for sepsis. Client #6 also received broad spectrum antibiotics for concern of sepsis and Narcan for concern of opioid overdose. A urine drug screen was completed at 7:09am and client #6 tested positive for Opiates and Fentanyl and negative for benzodiazepines. The records list the client's current medications as: Tylenol, Norvasc, Eliquis, Abilify, Aspirin, Lipitor, Zyrtec, Vitamin D3, Catapres, Delsym, Colace, Apresoline, Anusol, Lisinopril, Ativan, magnesium hydroxide, melatonin, Hiprex, Lopressor, Glycolax, Seroquel and Flomax. The records also revealed that client #6 was found to have significant bruising to her entire body. Client #6 was admitted to the hospital and stayed inpatient for 21 days.

Review on 3/2/26 of incident reports completed at the facility for client #6 revealed she had two falls on 1/28/26. Both reports stated no injuries noted.

Interview on 3/2/26 with the nurse revealed she received a call on 1/31/26 from staff saying client #6 was very weak and "just not acting herself". The nurse stated that she instructed staff to take client #6's vital signs and call an ambulance. The nurse revealed that staff A followed the ambulance to the hospital and she came shortly after to relieve her. The nurse stated that when she arrived at the hospital, client #6 did have some redness/bruising under her chin and bleeding at her gumlines. The nurse also stated that she knew client #6 had some bruising to her right thigh from a fall that occurred a few days prior to her hospital admission. The nurse stated she was unsure what had happened to cause the bruising/redness to client #6's chin but assumed maybe it happened while being worked on in the

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W 154	Continued From page 2 ambulance. The nurse confirmed she did not question any of the staff as to what may have caused it. The nurse also revealed that she received a call on the night of 1/30/26 from staff stating that client #6 was in a behavior and she gave permission for crisis medication Seroquel to be administered. The nurse confirmed that client #6 was prescribed a benzodiazepine, Lorazepam and 0.5mg were ordered to be administered twice daily. The nurse revealed she was unsure why the client tested negative for benzodiazepines and positive for Fentanyl and opioids. The nurse also revealed that client #6 had been diagnosed with a urinary tract infection and had begun the antibiotic Levofloxacin on 1/23/26. Further interview on 3/2/26 with the nurse revealed that after client #6 tested positive for Fentanyl and opioids at the hospital on 1/31/26, they had all other clients in the home drug tested. The nurse revealed that the facility believed it was a false positive due to the medication Seroquel and they had seen that happen at a sister facility. Review on 3/2/26 of the medication administration record (MAR) for client #6 revealed no documentation for the crisis medication Seroquel having been administered or any other as needed (PRN) medications on 1/30/26. Review on 3/2/26 of behavior documentation for client #6 revealed no documentation was completed for behaviors on 1/30/26. Review on 3/2/26 of the communication log kept in the home revealed a second shift note that stated client #6 was "given Tylenol and crisis med". A note from third shift stated, client #6 "was screaming non-stop, given crisis med at 10:24pm."	W 154		

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Review of the drug tests revealed that clients #1, #2, #4 and #5 were drug tested on 2/10/26 and client #3 was drug tested on 2/17/26. The drug tests revealed all other clients residing in the home tested negative for Fentanyl and opioids. Review of the drug tests results also revealed all clients tested negative for benzodiazepines except client #5.

Review on 3/2/26 of the current physicians' orders for all clients in the home revealed that clients #2, #4, #5 and #6 were all currently prescribed benzodiazepines.

Further interview on 3/2/26 with the facility nurse revealed she could not explain why 3 out of 4 clients in the home that are prescribed benzodiazepines tested negative for the medication. The nurse also confirmed that there was no documentation to support client #6 had a behavior or that crisis medication was administered.

Review on 3/2/26 of the facility's investigation for the drug test results for client #6 revealed 10 staff statements were taken, all stating that they had no knowledge of client #6 receiving any medications or drugs that were not prescribed to her. The investigations conclusion was that it was a false positive due to the medication Seroquel.

During an interview on 3/2/26 with the facility's nurse practitioner (NP) she revealed that to her knowledge Seroquel nor Levofloxacin would cause a false positive for Fentanyl. The NP also revealed that there can be false negatives for benzodiazepines but agreed that 3 out of 4 clients is an unlikely number of false negatives.

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W 154	Continued From page 4 A phone interview was conducted on 3/2/26 with the facility's medical director (MD). The MD stated that it is his belief that Seroquel can and does cause a false positive for Fentanyl and that he can't explain why 3 out of 4 clients tested negative for benzodiazepines that should have tested positive although false negatives do happen. Interview on 3/2/26 with the facility director revealed staff are drug tested upon hire, and again should suspicions or concerns arise. The director confirmed that the facility did not drug test the staff in the home because they believed client #6 had a false positive due to taking Seroquel. The director also confirmed they did not investigate injuries noted at the hospital because they were unsure if they occurred prior to client #6 leaving the facility to be transported to the hospital. The facility failed to thoroughly investigate potential issues that could have caused the client's to have tested negative for medications prescribed and for client #6 to have tested positive for Fentanyl and opioid's. The facility also failed to investigate the injuries noted at the hospital for client #6.	W 154		
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. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the	W 189		

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W 189	Continued From page 5 facility failed to ensure staff were sufficiently trained in medicaction administration (MAR) documentation and behavior documentation. The finding is: During an interview on 3/2/26 with the facility nurse revealed she received a call on the night of 1/30/26 from staff stating that client #6 was in a behavior and she gave permission for the crisis medication Seroquel to be administered. Review on 3/2/26 of the medication administration record (MAR) for client #6 revealed no documentation for the crisis medication Seroquel having been administered or any other as needed (PRN) medications. Review on 3/2/26 of behavior documentation for client #6 revealed no documentation was completed for behaviors on 1/30/26. Review on 3/2/26 of the communication log kept in the home revealed a second shift note that stated client #6 was "given Tylenol and crisis med". A note from third shift stated, client #6 "was screaming non-stop, given crisis med at 10:24pm". Interview on 3/2/26 with the facility director confirmed that staff should have documented any crisis or PRN medications given to client #6 and should have also completed behavior documentation.	W 189		