

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G325	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/21/2026
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NAME OF PROVIDER OR SUPPLIER LIFE, INC SLATESTONE ROAD GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 332 SLATESTONE ROAD , WASHINGTON, North Carolina, 27889
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W0130	<p>PROTECTION OF CLIENTS RIGHTS</p> <p>CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations and interviews, the facility failed to ensure clients were afforded privacy. This affected 3 of 6 audit clients (#1, #4 and #5). The findings are:</p> <p>A. During observations in the home on 4/21/26 the surveyors entered the home at 6:00am. Further observations revealed client #4 laying back on the couch. Additional observations revealed client #4's pants where unzipped and his disposable brief was visible. Further observations revealed at 6:02am, Staff B was walking through the living room and stated. "Why did you unzip your pants?" Client #4 continued laying back on the couch.</p> <p>During an interview on 4/21/26, the Home Manager (HM) stated third shift staff are the ones who assist client #4 with dressing.</p> <p>B. During evening observations in the home on 4/20/26 at 4:45pm, client #4 was getting his blood pressure taken outside in the backyard with client #2 present.</p> <p>Interview with Home Manager (HM) on 4/21/26 revealed client #4 should have been afforded privacy while his blood pressure being taken.</p> <p>C. During morning observations in the home on 4/21/26 at 6:15am, client #1 was getting his blood pressure taken and soaking his feet with his prescribed foot powder in his room with the door wide open for 20 minutes.</p> <p>Interview with HM on 4/21/26 revealed client #1 should have been afforded his privacy while his blood pressure was being taken and soaking his feet.</p>	W0130		
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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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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W0130	Continued from page 1 D. During morning observations in the home on 4/21/26 at 6:07am, client #5 getting dressed in his bedroom with the door wide open. Further observation revealed staff B was in the client #5's bedroom during this time. Client #5 was not prompted to close his bedroom door nor did staff B close the door. Interview with HM on 4/21/26 revealed client #5 should have been afforded his privacy while getting dressed.	W0130		
W0247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is NOT MET as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 6 audit client (#4) Individual Program Plan (IPP) included opportunities for choice and self-management. The finding is: During evening observations in the home on 4/20/26 at 4:49pm, client #4 stood up from the chair that he was sitting in, which was located in the living room. Staff D immediately stood up in front of client #4 and told him, "Sit down". Further observations revealed client #4 sitting back down in the chair and remaining there until dinner, which was served at 5:50pm. During morning observations in the home on 4/21/26 at 6:15am, client #4 was observed standing at the kitchen counter. Further observations revealed Staff C telling client #4 to sit down in a chair in the living room. Additional observations at 6:37am, revealed the Home Manager (HM) telling client #4 to sit down, which he did. Client #4 was observed standing up at 6:58am and Staff C was observed using her body to block him from moving. Client #4 was observed leaving the laundry room and walking back into the living room and sitting down. Further observations revealed Staff C standing between client #4's legs while he was sitting in the chair in the living room. Review on 4/21/26 of client #4's Individual Program Plan (IPP) dated 4/21/25 revealed, "I have no issues as far as mobility or gross motor skills". Further review revealed, "I am able to make day to day choices and encouraged to do so." During an interview on 4/21/26, the HM stated client #4 does have free movement within his environment. Further	W0247		

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W0247	Continued from page 2 interview revealed staff should not be using their bodies to block client #4 from moving. During an interview on 4/21/26, the Qualified Intellectual Disabilities Professional (QIDP) stated client #4 should be allowed free movement within his own environment.	W0247		
W0249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is NOT MET as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 6 audit clients (#6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of supervision. The finding is: During morning observations in the home on 4/21/26 the surveyors entered the home on 6:00am, client #6 was sitting in a chair in the living room. Further observations revealed Staff B who was assigned to be client #6's one on one was in another clients' bedroom, down the back hallway of the home assisting him with dressing. Additional observations revealed Staff B then went into another clients' bedroom and putting on a blood pressure cuff on his arm. Staff C was observed walking around the living room and then assisting client #4 with his clothing. Staff B did not return to where client #6 was until 6:23am. Review on 4/21/26 of client #6's IPP dated 7/9/25 stated, "I also receive 15 hours of 1 on 1 care daily." During an interview on 4/21/26, the Home Manager (HM) revealed Staff B has been assigned as client #6's one on one for 4/21/26 and her hours are from 5:00am until 9:00am. Further interview revealed Staff B should be in the same room as client #6. The HM also stated Staff B should have her eyes on client #6.	W0249		
W0340	NURSING SERVICES	W0340		

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W0340	<p>Continued from page 3 CFR(s): 483.460(c)(5)(i)</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record review and interview, nursing services failed to ensure staff were sufficiently trained in providing medical treatments. This affected 1 out of 6 audit clients (#1). The findings is:</p> <p>During the morning observations in the home on 4/21/26 at 6:05am, client #1 was sitting in his room alone with the blood pressure machine on his arm while soaking his feet with prescribe foot powder for over 20 minutes.</p> <p>Review on 4/21/26 of client #1 Individual Program Plan (IPP) dated 9/30/25 revealed "I am assessed annually in regards to his self-medication skills. I require intervention to verify the correct medication and dosage."</p> <p>Interview on 4/21/26 with Nurse revealed staff should have been with client #1 while his is blood pressure getting taken.</p>	W0340		
W0455	<p>INFECTION CONTROL</p> <p>CFR(s): 483.470(l)(1)</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation and interview, the facility failed to develop and implement an active program for prevention of transmission of communicable diseases. This affected all clients living in the home (#1, #2, #3, #4, #5 and #6). The finding is:</p> <p>During morning observations in the home on 4/21/26 from 6:00am to 6:20am, staff B was observed wearing gloves and doing various tasks such as laundry, helping client #1, #5, #6 get dressed and cleaning in the kitchen. At no time did staff change gloves in between tasks.</p>	W0455		

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W0455	Continued from page 4 Interview on 4/21/26 with Home Manager (HM) revealed staff should have changed gloves when doing various tasks and switching between clients.	W0455		
W0473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure that food was served at an appropriate temperature. This affected 1 out of 6 audit clients (#2). The finding is: During evening observations in the home on 4/21/26 at 5:30pm, clients started eating dinner. Further observation revealed, client #2 was walking around for 20 minutes as other clients ate. Client #2 finally sat down and ate his food at 5:50pm. The food was not re-heated before he ate, nor did staff check the temperature of the food prior to client #2 eating. Interview on 4/21/26 with Home Manager (HM) revealed client #2's food should have been re-heated.	W0473		