STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G320	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC OLD ROPER ROAD GROUP HOME	206 A OLD ROPER ROAD , PLYMOUTH, North Carolina, 27962

(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
W0340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) 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. This STANDARD is NOT MET as evidenced by: Based on observations, record review and interview, the facility failed to ensure all staff were sufficiently trained regarding the level of personal privacy client #1 requires while caring for her diabetic needs. This affected 1 of 3 audit clients (#1). The finding is: During observations at a local restaurant on 5/18/26 at 5:48pm, Staff A obtained necessary items to check client #1's blood sugar level. While seated at a table in the restaurant, the staff presented the items to the client and assisted her to give herself a finger stick, draw blood and obtain a reading on a glucose monitor. After obtaining the reading, client #1 returned the items to the staff and proceeded to begin consuming her dinner meal. Review on 5/19/26 of client #1's current physician's orders noted she receives blood sugar checks via a finger stick at least five times a day before meals and snacks. Interview on 5/19/26 with the facility nurse indicated medication technicians have been trained to provide privacy to clients while assisting them with a procedure such as a finger stick. The nurse further indicated the client should have been taken into the bathroom for this task, and it should not have been done in the dining room of the restaurant. The nurse acknowledged additional training may be needed in this area.	W0340		
E0013	Development of EP Policies and Procedures CFR(s): 483.475(b)	E0013		

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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E0013	Continued from page 1 §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.542(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section.	E0013		

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E0013	Continued from page 2 The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This STANDARD is NOT MET as evidenced by: Based on observations, document review and interviews, the facility failed to ensure the Emergency Preparedness Plan (EPP) included policies and procedures to address and manage the potential for equipment failure in the home. The finding is: Upon arrival to the home on 5/18/26 at 3:30pm, a box fan was observed operating in the living room and office of the home. During this time, several clients were in the living room area involved with leisure activities at the dining room table. Closer observation of a thermostat on the wall in the living room revealed the temperature was 82 degrees in the home. After being questioned by the surveyor regarding the elevated temperature, the Home Manager (HM) and Qualified Intellectual Disabilities Professional (QIDP) began calling other management staff to determine what they should do. Immediate interview with the HM and QIDP indicated a Heating, Ventilation, and Air Conditioning (HVAC) professional had been to the home earlier today to address an issue with the unit not working properly. They noted they thought it had been fixed. The QIDP acknowledged it was hot in the home and the system likely needed to be serviced again. Later interview with the QIDP noted due to the excess heat in the home, clients would go to a local restaurant for dinner and someone from maintenance would be addressing the AC issue while they were away from the home. Review on 5/18/26 of the facility's EPP (last reviewed on 12/17/25) revealed no policies and procedures to address an equipment failure such as the HVAC system. Interview on 5/19/26 with the QIDP II confirmed the EPP does not include specific policies and procedures regarding equipment failure resulting in extreme heat/cold in the home.	E0013		