PRINTED: 04/26/2018 FORM APPROVED OMB NO. 0938-0391

l l		(X3) DATE SURVEY COMPLETED	
<b>34G171</b> B. WING	<del></del>	04/24/2018	
NAME OF PROVIDER OR SUPPLIER  LAGRANGE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE  405 WEST WASHINGTON STREET  LA GRANGE, NC 28551		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
E 006 Plan Based on All Hazards Risk Assessment CFR(s): 483.475(a)(1)-(2)  [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:]  (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.*  *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.  *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.  (2) Include strategies for addressing emergency events identified by the risk assessment.  * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment.  * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to develop an emergency preparedness (EP) plan including the geographic location of the facility and the clients' needs of the facility in the risk assessment, utilizing an all-hazards approach. The finding is:	6		

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G171	B. WING			04/	24/2018
NAME OF PROVIDER OR SUPPLIER  LAGRANGE HOME			4	STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST WASHINGTON STREET LA GRANGE, NC 28551			
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
E 006	The facility did not hat based upon risk asset. Review on 4/23/18 of revealed the plan did information in regards of the facility and the in the risk assessment approach.  Interview on 4/23/18 of disabilities profession were aware of this an issue with the EP plan Development of EP P CFR(s): 483.475(b)  (b) Policies and procedure plan set forth in paragrament at paragrand the communication this section. The policies with the communication of the policies and updated the section. The policies and updated the communication of the policies.  *[For PACE at §460.8] procedures. The PACE at plan set of the paragrament at paragrament and updated the communication.	the facility's current EP plan not provide specific to the geographic location clients' needs of the facility at, utilizing an all-hazards  with the qualified intellectual al (QIDP) revealed they dere working to correct this in. colicies and Procedures  edures. [Facilities] must interegency preparedness es, based on the emergency graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be deat least annually.  ents for PACE and ESRD		006			
	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						

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STREET ADDRESS.CITY, STATE. ZIP CODE			34G171	B. WING _			04/:	24/2018
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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 annually.  *[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. The policies and procedures must be reviewed and updated at least annually. 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 interview, the facility failed to develop specific policies and procedures to address emergency preparedness, considering risk assessment and their communication plan in case of an emergency evacuation of the clients in the facility. The finding is:  During an interview on 4/23/18, with management revealed they did not have policies and procedures specifically for the emergency preparedness plan. However, they are working to meet this requirement.	PRÉFIX	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	Κ	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
E 032 Primary/Alternate Means for Communication E 032	E 013	emergencies, includir equipment, power, or emergencies; and nathreaten the health or staff, or the public. The must be reviewed and *[For ESRD Facilities procedures. The dialy implement emergency procedures, based or forth in paragraph (a) assessment at paragrand the communication this section. The policity reviewed and updated emergencies include, equipment or power from the emergencies, water is natural disasters likely geographic area. This STANDARD is represent and their case of an emergency prepared assessment and their case of an emergency the facility. The findir During an interview or revealed they did not procedures specifical preparedness plan. He	rig, but not limited to: Fire; water failure; care-related tural disasters likely to safety of the participants, he policies and procedures distributed at least annually.  at §494.62(b):] Policies and risis facility must develop and by preparedness policies and in the emergency plan set of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must be diat least annually. These but are not limited to, fire, ailures, care-related upply interruption, and by to occur in the facility's anot met as evidenced by:  the facility failed to develop procedures to address hess, considering risk communication plan in the procedures and the clients in the procedures and the procedures and the procedures and the procedures and the policies and the procedures are procedures and the procedures a	E	013			
[(c) The [facility] must develop and maintain an	E 032	Primary/Alternate Me CFR(s): 483.475(c)(3	ans for Communication )	E	)32			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED	
		34G171	B. WING			4/24/2018
NAME OF PROVIDER OR SUPPLIER  LAGRANGE HOME			STREET ADDRESS, CITY, STATE, ZIP CO 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	•		
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E 032	that complies with Fe and must be reviewe annually.] The commall of the following:  (3) Primary and alter communicating with (i) [Facility] staff. (ii) Federal, State, tril emergency manager  *[For ICF/IIDs at §48 alternate means for of ICF/IID's staff, Feder local emergency mar This STANDARD is Based on document facility failed to devel communicating with local governments dufinding is:  The facility failed to of for communicating with governments during with governments during is:	ness communication plan ederal, State and local laws d and updated at least unication plan must include  nate means for the following: bal, regional, and local nent agencies.  3.475(c):] (3) Primary and communicating with the al, State, tribal, regional, and nagement agencies. not met as evidenced by: ation and interviews, the op an alternate means for facility staff, regional and uring an emergency. The  develop an alternate means ith staff, regional and local an emergency.  f the facility's emergency id not include any	E 03	32		
E 037		an emergency.	E 03	37		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		34G171	B. WING		04/24/2018		
NAME OF PROVIDER OR SUPPLIER  LAGRANGE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551		1 04242010		
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E 037	Continued From pa	ge 4	E 03	37			
	ASCs, PACE organ	n. The [facility, except CAHs, izations, PRTFs, Hospices, s] must do all of the following:					
	policies and proced staff, individuals pro arrangement, and v expected role.  (ii) Provide emerger least annually.  (iii) Maintain docum (iv) Demonstrate staprocedures.  *[For Hospitals at § at § 491.12:] (1) Traior RHC/FQHC] mus (i) Initial training in epolicies and proced staff, individuals pro arrangement, and v expected roles.  (ii) Provide emerger least annually.  (iii) Maintain docum (iv) Demonstrate staprocedures.  *[For Hospices at § hospice must do all (i) Initial training in epolicies and proced hospice employees services under arranexpected roles.	emergency preparedness ures to all new and existing oviding services under folunteers, consistent with their ancy preparedness training at entation of the training. aff knowledge of emergency 482.15(d) and RHCs/FQHCs ining program. The [Hospital st do all of the following: emergency preparedness ures to all new and existing oviding on-site services under folunteers, consistent with their ancy preparedness training at entation of the training. aff knowledge of emergency 418.113(d):] (1) Training. The of the following: emergency preparedness ures to all new and existing aff knowledge of emergency for the following: emergency preparedness ures to all new and existing and individuals providing ingement, consistent with their					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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NAME OF PROVIDER OR SUPPLIER  LAGRANGE HOME			•	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	1 34242313		
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E 037	least annually. (iv) Periodically reviewergency prepare employees (includin special emphasis pl procedures necessatothers.  *[For PRTFs at §44 program. The PRTF (i) Initial training in expolicies and procedustaff, individuals program arrangement, and vexpected roles. (ii) After initial training preparedness training (iii) Demonstrate state procedures. (iv) Maintain docum preparedness training in exposedures. (iv) Maintain docum preparedness training in exposedures and procedures and procedustaff, individuals program arrangement, contravolunteers, consisted (ii) Provide emerger least annually. (iiii) Demonstrate state procedures, includir what to do, where to case of an emergent.	ew and rehearse its dness plan with hospice g nonemployee staff), with acced on carrying out the ary to protect patients and and the following: emergency preparedness ures to all new and existing viding services under colunteers, consistent with their and at least annually. If knowledge of emergency entation of all emergency entation of all emergency ng.  84(d):] (1) The PACE of all of the following: emergency preparedness ures to all new and existing viding services under actions of all emergency ng.  84(d):] (1) The PACE of all of the following: emergency preparedness ures to all new and existing viding on-site services under actors, participants, and ant with their expected roles. In the following at least raining at a left knowledge of emergency of ginforming participants of the go, and whom to contact in	E 03				

AND DUAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G171	B. WING			04/	24/2018
NAME OF PROVIDER OR SUPPLIER  LAGRANGE HOME			4	TREET ADDRESS, CITY, STATE, ZIP CODE  05 WEST WASHINGTON STREET  A GRANGE, NC 28551			
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E 037	CORF must do all of (i) Provide initial train preparedness policies and existing staff, ind under arrangement, a with their expected ro (ii) Provide emergence least annually. (iii) Maintain document (iv) Demonstrate staff procedures. All new pand assigned specific the CORF's emergent their first workday. The include instruction in alarm systems and siequipment.  *[For CAHs at §485.6] The CAH must do all (i) Initial training in empolicies and procedure reporting and extinguland where necessary personnel, and guest cooperation with fireficial authorities, to all new individuals providing and volunteers, consiroles.  (ii) Provide emergence least annually.  (iii) Maintain document (iv) Demonstrate staff procedures.	the following: ing in emergency is and procedures to all new lividuals providing services and volunteers, consistent oles. by preparedness training at intation of the training. If knowledge of emergency personnel must be oriented by preparedness regarding by plan within 2 weeks of the training program must the location and use of gnals and firefighting  1025(d):] (1) Training program. In of the following: In ergency preparedness I res, including prompt I ishing of fires, protection, I is, evacuation of patients, I is, fire prevention, and I ighting and disaster I and existing staff, I services under arrangement, I istent with their expected  The provention of the training at The provention of the training at The provention of patients, The prevention of patients of the prevention of patients, The prevention of patients of the prevention of patients, The prevention of patients of the prevention of th	E	037			

NAME OF PROVIDER OR SUPPLIER  LAGRANGE HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  405 WEST WASHINGTON STREET  LA GRANGE, NC 28551  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  CEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  E 037 COntinued From page 7 CMHC must provide initial training in emergency		
NAME OF PROVIDER OR SUPPLIER  LAGRANGE HOME  STREET ADDRESS, CITY, STATE, ZIP CODE  405 WEST WASHINGTON STREET  LA GRANGE, NC 28551  ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  E 037 Continued From page 7  E 037  STREET ADDRESS, CITY, STATE, ZIP CODE  405 WEST WASHINGTON STREET  LA GRANGE, NC 28551  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	24/2018	
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2 007	(X5) COMPLETION DATE	
preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually.  This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure direct care staff were sufficiently trained on the facility's emergency plan (EP). The finding is:  Staff had not received training on the emergency plan (EP).  Review on 4/23/18 of facility documents revealed no documented specific training for direct care staff in regards to the EP.  Staff interviews (2) on 4/23/18 revealed they have been trained regarding fire drills and disaster drills; however, the staff could not provide specific details regarding the facility's EP program.  Interview on 4/23/18 with the qualified intellectual disabilities professional (QIDP) revealed direct care staff had been trained regarding fire drills and disaster drills. However, there had not been any formal training provided concerning the new EP.  W 210  INDIVIDUAL PROGRAM PLAN  UN 210  UN 210  INDIVIDUAL PROGRAM PLAN  UN 210  CFR(s): 483.440(c)(3)		

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W 210	assessments or rea		W 21	0		
	Based on record re failed to ensure the performed accurate after admission. Th admitted audit client	not met as evidenced by: view and interview the facility interdisciplinary team assessments within 30 days is affected 1 of 1 newly is (#3). The finding is: reive a dental or vision ely manner.				
	he was admitted into Further review of cli dental assessment review of client # 3's assessment dated 1	of client #3's record revealed to the facility on 9/7/17. ent #3's record revealed a dated 10/25/17. Further a record revealed a vision 0/16/17. No additional dental at were available in the				
	confirmed the denta were done at the ea	on 4/24/18, the nurse I and vision assessments rliest times possible. However as not in a timely matter.				