STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G051	A. BUILDING _____ B. WING _____	08/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA SPRINGS ROAD HOME	309 LAURA SPRINGS DR SALISBURY, NC 28144

(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
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, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to develop specific facility-based strategies as part of their emergency preparedness plan. The finding is: A. Review of the facility's emergency plan (EP), conducted on 8/6/18 revealed identified risks	E 006		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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E 006	Continued From page 1 included power outage, inclement weather and shelter in place strategies among others. Observations conducted in the home on 8/6/18 - 8/7/18 revealed an inadequate supply of food and water was available in the home to support risks identified in the EP. Interviews conducted with staff in the group home as well as the qualified intellectual disabilities professional (QIDP) revealed no basic inventory of emergency supplies had been developed and/or maintained as part of the current emergency plan. B. Review of the EP revealed information provided regarding individual residents of the home was limited to the general information included on the face sheet as well as prescribed diet information, however, no comprehensive, specific information was included in the EP which would inform persons working with the clients during an emergency situation,who were unfamiliar with the clients, regarding communication needs, appropriate behavioral interventions or support required for activities of daily living. Interview with the QIDP on 8/7/18 revealed comprehensive information regarding the needs of individual clients residing in the home had been developed, however, it was not included in the EP at this time.	E 006		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.	W 153		

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W 153	Continued From page 2	W 153		

This STANDARD is not met as evidenced by:
Based on facility document review and interview, the facility failed to ensure all allegations of abuse/neglect were reported to the administrator immediately for 1 of 1 investigations reviewed. The finding is:

Review of the facility's abuse/neglect investigations on 8/7/18 revealed an investigation started on 7/30/18 and was completed by the facility on 8/7/18. Review of the investigation revealed on the morning of 7/30/18 Staff A spoke with the facility administrator (FA) and the qualified intellectual disabilities professional (QIDP) regarding a conversation which occurred earlier that morning with Staff B during which Staff B stated to Staff A that Staff B had witnessed Staff C threaten client #5 with a knife in the kitchen of the group home. Continued review of the 7/30/18 abuse investigation revealed that during the course of the investigation Staff B reported having "heard" Staff C had administered Benadryl to client #3 on several occasions, without permission from the nurse, "to calm him down so he would fall asleep". Also documented as having been discovered during the 7/30/18 investigation, Staff B stated both the incident involving Staff C threatening client #5 with a knife and the incident involving Staff C administering Benadryl to client #3 without permission had occurred one and one-half to two weeks prior to Staff B discussing the incidents with Staff A on 7/30/18. It is noted that the facility suspended both Staff B and Staff C immediately upon notification of these incidents pending the outcome of the facility's investigation.

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W 153	Continued From page 3 Interviews conducted on 8/7/18 with the FA and QIDP revealed this investigation had been initiated immediately upon receiving the report from Staff A, however, the incidents described by Staff B had occurred approximately one and one-half to two weeks prior to Staff B discussing them with Staff A, who then reported them to administration. These interviews further revealed all staff are expected to report any allegations of possible abuse, neglect or exploitation to the administrator immediately.	W 153		
W 249	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 observation, record review and interview, the facility failed to assure 1 of 3 sampled clients (client #1) received a continuous active treatment program consisting of needed interventions in sufficient number and frequency to support the individual program plan (IPP). The finding is: Observations conducted on 8/6/18 at 5:35 PM revealed client #1 loaded onto the facility van for a supper outing, accompanied by staff and another client residing in the home. Further	W 249		

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W 249	Continued From page 4 observations conducted on 8/7/18 at 8:35 AM revealed client #1 loaded onto the facility van for transportation to the day program facility. Client #1 was not observed to wear a helmet and staff were not observed to prompt client #1 to wear a helmet at any time during the 8/6/18 - 8/7/18 survey. Review of the record for client #1, conducted on 8/6/18 and 8/7/18, revealed an IPP dated 3/14/18 documenting client#1 "wears a soft shell helmet while loading on and off the van/school bus and when involved in any physical activity for safety. Staff are to monitor for falls at all times." Interview conducted with the qualified intellectual disabilities professional and the nurse on 8/7/18 verified client #1's current IPP prescribes the use of a soft shell helmet whenever he is loading onto the van or school bus, and further verified staff should consistently prompt client #1 to wear his helmet as prescribed.	W 249		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the system for medication administration failed to assure all medications were administered at the prescribed time for 1 of 2 clients observed during medication administration (#3). The finding is:	W 368		

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W 368	Continued From page 5 On 8/7/18 at 7:20 AM, client #3 was observed to enter the medication administration area and was assisted by staff to take medications including: Strattera 80 mg., Klonopin 0.5 mg.-1/2 tab., Zimpat 250 mg.-2 and 1/2 tabs., Carbatrol 300 mg.-three caps., Immodium 2 mg., Mag-Ox 400 mg.-two tabs., Oscal/Vitamin D 500/500 mg., Riperdal 2 mg. and Synthroid 75 mcg. Review of the record for client #3, conducted on 8/7/18, revealed physician's orders dated 5/29/18 prescribing Synthroid 75 mcg. to be given daily at 8:30 PM. Interview conducted with the nurse on 8/7/18 revealed the client's physician had ordered the Synthroid 75 mcg. to be given at 8:30 PM specifically in order to be given away from meals and increase efficacy. This interview further verified the physician would be notified of the medication error related to the Synthroid 75 mcg. being given at the wrong time on 8/7/18.	W 368		