STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G196	A. BUILDING _____ B. WING _____	09/05/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOOD GROUP HOME	109 LONON AVENUE MARION, NC 28752

(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 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) [(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 annually.] At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical	E 015		

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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E 015	Continued From page 1	E 015		

supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(2) Emergency lighting.
(3) Fire detection, extinguishing, and alarm systems.
(C) Sewage and waste disposal.
This STANDARD is not met as evidenced by:
Based on observation, record review and interview, the facility failed to implement the emergency preparedness policy relative to the provision of subsistence needs for clients and staff. The finding is:

Review of the facility's emergency preparedness plan, conducted on 9/4/18, revealed a policy relative to the provision of subsistence needs for clients and staff which was updated 2/18. Continued review of this policy revealed documentation stating the facility should maintain at least a three day supply of non-perishable food and water, to include a minimum of 24 gallons of water.

Observation of the emergency food and water supply present in the group home on 9/4/18 revealed an adequate supply of emergency food, however, no emergency water supply was available. Interview with the group home manager on 9/4/18 verified no emergency water was currently available in the group home. Interview with the facility administrator on 9/5/18 verified 24 gallons of water should be available in the group home as specified in the facility's emergency preparedness plan.

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W 130	Continued From page 2	W 130		
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide privacy for 1 of 3 sampled clients (#2) during care of personal needs and activities of daily living performed in his bedroom. The finding is: Observations conducted throughout the 9/4/18 - 9/5/18 survey revealed no window covering of any kind was in place in client #2's bedroom. Further observations conducted on 9/5/18 at 6:05 AM revealed staff staff knocked on client #2's closed bedroom door and prompted him to wake up and get dressed. Continued observations revealed client #2 exited his bedroom dressed for the school day. Interview with the group home manager, conducted on 9/5/18, revealed client #2 has a history of tearing the window coverings off of his bedroom window. Further interview with the group home manager and the qualified intellectual disabilities professional revealed no knowledge of the length of time client #2's bedroom window had been without any covering.	W 130		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan,	W 249		

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W 249	Continued From page 3 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 implement needed interventions in sufficient number and frequency to support the achievement of behavioral objectives identified in the individual program plans (IPP's) relative to physical aggression for 2 of 3 sampled clients (#2 and #3). The findings are: Observations conducted on 9/4/18 at 4:50 PM revealed client #3 was prompted by staff to begin her exercise objective to walk laps in the hallway of the home. Continued observations at 5:00 PM revealed client #2 joined client #3 in walking laps in the hallway. On-going observations revealed client #2 walking directly behind client #3 in very close proximity. On three separate occasions between 5:24 PM and 5:28 PM client #3 slowed her pace and attempted to stop walking. Each time client #3 attempted to slow her pace or stop walking, client #2 was observed to place his hands on client #3's shoulders from behind and physically redirect her to continue walking. Staff was not observed to intervene during these episodes. Further observations at 5:30 PM revealed client #3 stopped walking and stood with her back against a wall in the dining room. Client #2 was then observed to face client #3 in very close proximity and begin to tap client #3 on the	W 249		

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W 249	Continued From page 4	W 249		

left hand with his right fist. Client #3 was then observed to pinch client #2 on the left inner arm, just above the elbow. Staff was observed to intervene at that time by redirecting client #3 and assessing client #2 for injury.

Review of the record for client #2 revealed an IPP dated 9/17/17 which included a behavior support plan (BSP) documenting target behaviors including verbal disruption, property destruction, manic behavior, self-injurious behavior and physical aggression. Physical aggression was defined as hitting, slapping, pushing, kicking and biting others. Interventions documented in the BSP stated : If (client #2) begins to demonstrate self-injury, aggression or property destruction, immediately block and interrupt the behavior and attempt to re-direct to alternative behavior.

Review of the record for client #3 revealed an IPP dated 8/22/18 including a BSP documenting target behaviors including non-compliance, verbal disruption, self-injurious behavior, tantrums, toileting accidents, PICA and physical aggression. Physical aggression was defined as attempting or actually hitting, kicking, scratching, biting, choking, pushing or pinching another person. Interventions for physical aggression included reducing demands, moving others away and waiting for her to calm down.

Further review of facility records, conducted on 9/5/18, revealed recent facility incident reports had indicated a trend in incidents of physical aggression between client #2 and client #3. Review of staff training documentation dated 8/1/18 revealed staff should monitor closely and maintain separation of clients during participation in walking/exercise objectives to prevent incidents

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W 249	Continued From page 5 of physical aggression between clients. Interview with the qualified intellectual disabilities professional and the group home manager verified staff should assure clients participate separately in exercise/walking program and further verified staff should monitor clients at all times when participating in exercise programs to prevent peer to peer aggression.	W 249		