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E 007	EP Program Patient Population CFR(s): 483.475(a)(3) [(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:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This STANDARD is not met as evidenced by: Based on review of facility records and interviews, the facility failed to assure the Emergency Preparedness Plan (EPP) contained specific current information relative to the needs of 6 of 6 clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: Review on 7/31/19 and 8/1/19 of the facility's EPP manual titled "Laura Springs Emergency Operations Plan" dated October 2017, revealed limited client information relative to behavior support plans (BSPs), adaptive equipment needs, and personal possessions. Continued review of the facility's EPP manual revealed the person centered plans (PCPs) for various clients were not current. Interview on 8/1/19 with the qualified intellectual disabilities professional (QIDP) verified the facility did not include current specific information relative to behavior support plans (BSPs),	E 007		

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 007	Continued From page 1 adaptive equipment needs, and personal possessions of each client. The QIDP further verified the facility's current EPP should contain current client specific information to assist persons unfamiliar with each client to provide appropriate, safe care in an emergency. In addition, the QIDP verified the facility's current EPP manual needed to be updated, as all information in the manual was not current.	E 007		
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.	E 015		

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E 015	Continued From page 2 *[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 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: The facility failed to ensure the provision of subsistence needs for clients and staff, regardless of whether they evacuate or shelter in place, included, but was not limited to, food and water, as required by Emergency Preparedness Plan (EPP) regulations. The finding is: Observations conducted on 8/1/19 of the group home's designated pantry area containing EPP subsistence supplies, along with the facility qualified intellectual disabilities professional (QIDP), revealed the following: 9 one-gallon water containers, 1 large transparent plastic container almost half full with an assortment of canned, ready to eat food items, and another large transparent plastic container with 4 canned food items and 2 small jars of baby food inside.	E 015		

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E 015	Continued From page 3 Continued observations inside the designated pantry area containing EPP subsistence supplies revealed 3 unopened cases of Ensure and 1 opened case of Ensure pudding supplements. Further observations revealed, and substantiated by the QIDP, none of the unopened and/or opened Ensure supplement cases to be included among the facility's EPP subsistence supplies. Review on 8/1/19 of the facility's EPP manual titled "Laura Springs Emergency Operations Plan" dated October 2017, notably revealed policy and procedures, risk assessments, and collaboration with county emergency preparedness officials. Continued review of the facility's EPP manual, and substantiated by the QIDP, revealed the following "Families should bring snack, drinks, linens, personal items whenever possible. Food will be provided in the cafeteria from a limited menu and at reasonable prices. Food for residents will be the priority." Interview on 8/1/19 with the QIDP confirmed subsistence supplies should include prescribed supplements such as Ensure. Further interview revealed the facility's day program site is one of the identified evacuation sites and this site has a kitchen area. Continued interview with the QIDP confirmed the group home does not currently have sufficient, designated, subsistence EPP supplies such as food, for clients and staff, to meet current EPP regulations regardless of whether they evacuate or remain in place, at the group home.	E 015		
E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an	E 032		

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emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following:

(3) Primary and alternate means for communicating with the following:
(i) [Facility] staff.
(ii) Federal, State, tribal, regional, and local emergency management agencies.

*[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies.
This STANDARD is not met as evidenced by:
Based on staff and facility management interviews, the facility failed to ensure the facility's Emergency Preparedness Plan (EPP) included an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is:

Interview on 8/1/19 with group home staff B and E pertaining to the facility's EPP revealed in the event the group home's phone is not working, they would use their personal cell phones.

Interview on 8/1/19 with the facility qualified intellectual disabilities professional (QIDP) confirmed in the event the group home's landline phone is not working, staff will use their personal cell phones. Ongoing interviews with the QIDP confirmed the facility did not have an alternate means of communication. Subsequent interview on 8/1/19 with the facility administrator confirmed the facility's EPP plan maintains group home staff are to keep their personal cell phones charged in

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E 032	Continued From page 5 the event the group home's phone is not working, to ensure alternate EPP communication.	E 032		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 6 (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure exercises were conducted annually to test the facility's emergency preparedness plan (EPP), as required. The finding is: Review on 8/1/19 of the facility's EPP revealed current staff training documentation pertaining to tabletop instruction conducted during regular, monthly staff meetings. Continued review revealed no documentation to indicate any testing or a full-scale community based exercise had been conducted during the past year. Interview with the facility qualified intellectual disabilities professional (QIDP) revealed no system was in place to assure testing of the facility's EPP, and	E 039		

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E 039	Continued From page 7 further verified no full-scale community based exercise had been conducted during the past year to test the facility's EPP.	E 039		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, review of records and interview, the team failed to ensure the person centered plan (PCP) for 1 of 3 sampled clients (#2) included objective training to address needs relative to meal preparation and household chores. The finding is: Observation in the group home on 7/31/19 at 4:00 PM revealed client #2 to sit in his wheelchair in the dining room holding a yellow ball until 4:45 PM. Continued observations revealed from 4:45 PM to 5:00 PM client #2 to sit and hold an empty sip cup. Further observations revealed client #2 to sit in his wheelchair in the dining area unengaged in any leisure or program activity until 5:00 pm when staff E wheeled client #2 to the medication closet to receive his afternoon medication. Observations revealed for a total of 60 minutes, client #2 sat unengaged in any objective training or structured, leisure activity. Observations in the group home on 8/1/19 at 7:30 AM revealed client #2 to sit in his wheelchair in the dining room holding a blue ball. Continued	W 227		

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W 227	Continued From page 8 observations revealed at 7:55 AM staff D wheeled client #2 to the living room area, as client #2 continued to hold a blue ball. Further observations revealed client #2 to be visibly unengaged in any leisure or program activity until 8:30 AM when staff B wheeled client #2 to the medication closet for his morning medications. Observations revealed for a total of 60 minutes, client #2 sat unengaged in any objective training or structured, leisure activity. Review of records on 8/1/19 for client #2 revealed a PCP dated 11/28/18. Review of the PCP revealed objectives relative to mealtime (feeding), money management, communication, and physical therapy (PT) exercises. Further review of client #2's PCP revealed an adaptive behavior inventory (ABI) dated 11/18 that identified client #2 to have no independence with housekeeping, personal independence, meal preparation, physical recreation and leisure. Interview with the QIDP confirmed client #2 should have been engaged in an active treatment throughout the afternoon and morning routine. Continued interview with the QIDP confirmed client #2 could use more objectives and goals, as identified in his ABI, in the areas of meal preparation and household chores.	W 227		
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	W 249		

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objectives identified in the individual program plan.

This STANDARD is not met as evidenced by:
Based on observation, interview and record review, the interdisciplinary team failed to assure consistent interventions and services to support the needs identified in the person centered plan (PCP) for 1 non-sampled client (#3) and 1 of 3 sampled clients (#2) relative to active treatment. The findings are:

A. The facility failed to consistently provide active treatment for client #3.

Observations at the group home on 7/31/19 at 11:45 AM revealed client #3 to be seated at the dining table consuming his pureed lunch meal in a deep dish container with hand over hand staff assistance using his adaptive spoon. Continued observations revealed client #3's deep dish container was within his reach. Further observations revealed client #3 to hold and to drink from his own sippy cup, throughout the lunch meal. Subsequent observations revealed while client #3 walked to the bathroom, to his bedroom and around the home, group home staff were nearby the client.

Observations at the group home on 7/31/19 from 4:00 PM to 5:00 PM revealed client #3 to continually crawl on the kitchen and dining room floor as staff F redirected the client towards other areas in the group home. Further observations at 5:03 PM revealed client #3 to be seated at the dining table and staff F to pour client #3's liquids. Subsequent observations revealed staff F to

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spoon feed client #3 his pureed dinner meal using client #3's adaptive spoon. Ongoing observations revealed staff F to position client #3's deep dish container on the dining table outside of client #3's reach and to spoon feed client #3 his dinner meal at the dining table. Additional observation revealed client #3's sippy cup was positioned within the client's reach and client #3 continued to hold and to drink from his sippy cup throughout the dinner meal.

Interview on 7/31/19 with staff F at 4:30 PM revealed client #3 will quickly grab at his food and cause food items to spill.

Review of client #3's record revealed a PCP dated 12/12/18. Continued review of client #3's PCP revealed client #3 requires full physical assistance with most skills. Client #3 has not presented to follow directions, and requires hand-over-hand assistance with many tasks. Client #3 requires full assistance with eating. Further review of the PCP revealed Client #3 does not tolerate hand-over-hand assistance. Staff should use a benign touch in redirecting to ensure his safety when exhibiting self-injurious behavior and/or while encouraging participation in completing a task.

Interview with the qualified intellectual disabilities professional (QIDP) on 8/1/19 revealed client #3 is on one to one supervision during meals. Continued interview confirmed staff should use hand over hand assistance with client #3 during his meals.

B. The facility failed to provide consistent active treatment for client #2.

Observations in the group home on 7/31/19 at

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4:00 PM revealed client #2 to sit in this wheelchair in the dining room holding a yellow ball until 4:45 PM. Continued observations revealed from 4:45 PM to 5:00 PM client #2 to hold an empty sip cup. Further observations revealed client #2 to remain in the dining area unengaged in any leisure or program activity until 5:00 pm when staff E wheeled client #2 to the medication closet to receive his afternoon medication of Miralex. Observations revealed for a total of 60 minutes, client #2 sat unengaged in any objective training or structured, leisure activity.

Observations in the group home on 8/1/19 at 7:30 AM revealed client #2 to sit in his wheelchair in the dining room holding a blue ball. Continued observations revealed at 7:55 AM staff D wheeled client #2 to the living room area, as client #2 held a blue ball. Further observations revealed client #2 to be visibly unengaged in any leisure or program activity until 8:30 AM when staff B wheeled client #2 to the medication closet for his morning medications. Observations revealed for a total of 60 minutes, client #2 sat unengaged in any objective training or structured, leisure activity.

Review of records on 8/1/19 for client #2 revealed a PCP dated 11/28/18. Continued review of client #2's PCP revealed the objectives to include communication, physical therapy (PT) exercises, and money management. Further review revealed client #2's PT recommendations noted the client should continue with knee immobilizer at least 3 times a week, for 30 to 45 minutes, to help with range at the knee, erect standing/posture, and to wear shoes when he is out of bed for mobility and foot safety.

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W 249	Continued From page 12 Subsequent review of the PCP revealed the facility should encourage client #2 to be out of his wheelchair, at times during the day, and to sit in a regular chair to prevent falling. In addition, a brief review of documentation relative to client #2's PT exercise located at the group home revealed recent limited data collection of which only data for 7/1/19, 7/2/19 and 7/23/19 was documentated. Interview with the facility qualified intellectual disabilities professional (QIDP) confirmed client #2's training objectives are current and client #2 should have been engaged in active treatment such as his PT exercises in the afternoon and morning routine.	W 249		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: The facility failed to ensure food was served in the form consistent with the needs of 1 of 3 sampled clients in the home (#2) as evidenced by observation, interview and record verification. Observations in the group home on 8/1/19 at 7:15 AM revealed staff D feeding client #2 his breakfast meal which consisted of pancakes and turkey sausage. Continued observations revealed client #2's turkey was cut into ¼ inch bite size pieces. Further observations revealed staff D using client #2's adaptive spoon to feed the client the breakfast meal. Subsequent observations revealed while staff D made several attempts to feed client #2 the breakfast meal,	W 474		

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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
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client #2 refused to eat from his adaptive spoon and instead chose to eat the remainder of his breakfast meal using his fingertips.

Review of records for client #2 on 8/1/19 revealed a PCP dated 11/28/18. Continued review revealed client #2 has a chopped diet with mechanical meats and double portions. Further review revealed client #2's prescribed diet also includes 2-gram sodium diet, high calorie supplement drinks of BOOST® and Carnation Instant Breakfast for 3 times a day, and snack with whole milk. Subsequent review revealed client #2's physician order, dated 5/9/19, noted his diet is ground consistency for meats, and all other foods ¼ inch consistency. In addition, client #2's physician order noted "weight gain" for the client's diet.

Interview on 8/1/19 with staff F revealed a knife was used to cut client #2's sausage and pancakes into pieces. Further interview with staff F revealed client #2's diet consistency is chopped meats and bite size pieces as small as rice.

Additional interview with the facility qualified intellectual disabilities professional (QIDP) confirmed client #2's diet consistency is mechanical soft meats and all other foods are chopped. Further interview with the QIDP confirmed client #2's turkey sausage should have been mechanical soft consistency.