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 _____	R 08/04/2021

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
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, record review and interview the facility failed to assure the right to privacy during the provision of personal care for 1 of 6 clients (#2). The finding is: Observation in the group home on 8/4/21, during the follow-up survey, revealed client #2 to engage in self-stimulation activity at various times while sitting in common areas of the group home. Continued observation throughout the morning, from 7:55 AM until 10:30 AM, revealed staff to inconsistently intervene with client #2 regarding self-stimulation behaviors with either leaving the client in the common area and providing verbal redirection or assisting the client to his bedroom. Interview with staff C on 8/4/21 revealed client #2 will often engage in self-stimulation behaviors in common areas of the group home and on outings in the community. Continued interview with staff C revealed she had been directed by clinical staff to not allow client #2 to go to his room for privacy during self-stimulation behaviors due to the client's need to be engaged with others and involved with activities. Subsequent interview with staff A, B and C verified client #2 engages in self-stimulation activity frequently and had no guidelines to address the behavior. Review of records for client #2 on 8/4/21 revealed a person centered plan (PCP) dated 1/25/21.	W 130		

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

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W 130	Continued From page 1 Continued review of records revealed no behavior support plan for client #2. Subsequent review of client #2's record revealed no documented history or behavior related to self-stimulation behavior. Interview with clinical staff on 8/4/21 verified client #2 has a history of engaging in self-stimulation activity. Continued interview with clinical staff verified staff should support client #2 with obtaining privacy when the client engages in self-stimulation behavior. Additional interview with clinical staff verified client #2 had no guidelines regarding self-stimulation behavior and there was no evidence of any staff training relative to client #2's self-stimulation behavior to ensure staff are trained to address client #2's behavior and right to privacy.	W 130		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure staff were sufficiently trained relative to the ambulation needs for 1 of 6 clients (#2) . The finding is: Observation in the group home on 8/4/21, during the follow-up survey, at 8:00 AM revealed staff to assist client #2 with ambulation in a wheelchair, with no socks or shoes on, to the medication room for medication administration. Continued observation revealed staff to assist client #2 with	W 189		

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W 189	Continued From page 2 ambulation from the medication room to the living room of the group home for leisure activity with watching television. Further observation revealed staff to assist client #2 with ambulation to his bedroom and later to return to the dining room in socks with no shoes. Review of the plan of correction (POC), from the 4/22/21 recertification survey, revealed client #2 would have guidelines implemented to address the need to wear shoes during wheelchair ambulation. Continued review of the POC from the 4/22/21 survey revealed an in-service would be conducted with staff to address client #2's need to wear shoes for safety during ambulation. Review of records for client #2 on 8/4/21 revealed no guidelines or training of staff to address client #2's need for shoes during ambulation. Interview with staff C on 8/4/21 revealed client #2 often removes his shoes while sitting in his wheelchair. Continued interview with staff C revealed she was unaware of any guidelines that require client #2 to wear shoes during ambulation. Interview with clinical staff on 8/4/21 verified client #2 should wear shoes during ambulation for safety. Subsequent interview with clinical staff verified an in-service training should have been completed with the POC of the 4/22/21 survey and no evidence was available to support staff training had been conducted.	W 189		
{W 288}	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.	{W 288}		

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{W 288}	Continued From page 3	{W 288}		

This STANDARD is not met as evidenced by:
Based on observations, record review, and interviews, the facility failed to assure techniques to manage inappropriate behavior were not used as a substitute for an active treatment program for 1 of 3 sampled clients (#4). The finding is:

Observations at the group home on 4/21/21 from 4:30 PM to 5:45 PM revealed both hallway bathrooms in the facility to have no hand soap. Continued observations revealed various clients (#1, #3, #4, #5, #6) to be prompted by staff to wash their hands before dinner. Further observations revealed various clients (#1, #3, #4, #5, #6) to enter the kitchen area where staff A provided a few drops of hand soap into the hands of each client. Additional observations revealed clients to enter the hallway bathrooms to wash their hands then exit to sit at the dining table. Subsequent observations revealed the hand soap supply for both facility bathrooms to be stored on the kitchen counter.

Observations in the medication room of the group home on 4/22/21 revealed a white board with a written note which indicated: Client #4 is over using his toothpaste, its in his medication basket when he needs to use it.

Review of records for client #4 on 4/22/21 revealed a person centered plan (PCP) dated 2/24/20. Review of client #4's PCP revealed a behavioral support plan (BSP) dated 11/12/20. Review of the BSP for client #4 revealed target behaviors of physical aggression, social isolation, inappropriate food acquisition and property destruction. Further review of client #4's PCP and

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{W 288}	Continued From page 4 BSP revealed no target behaviors relative to misuse of hygiene items. Interview with Staff A and Staff C on 4/21/21 confirmed hand soap from the hallway bathrooms of the group home are stored on the kitchen counter. Continued interview with Staff C revealed hand soap products are not kept in either bathroom of the facility because client #4 misuses and wastes the soap without staff supervision. Interview with interim qualified intellectual disability professional (QIDP) on 4/22/21 revealed hand soap in the facility should not be kept in the kitchen. The QIDP subsequently verified client #4's toothpaste should not be kept locked in the medication room as no formal interventions have been implemented to address the inappropriate use of hygiene products by client #4. Observation in the group home on 8/4/21, during the follow-up survey, revealed client #4 to have no toothpaste in his hygiene basket. Continued observation revealed staff to retrieve a new tube of toothpaste from a supply closet and to provide the full sized tube of toothpaste to the client. Subsequent observation revealed client #4 to go to the bathroom to brush his teeth. Additional observation revealed staff to supervise client #4 with toothbrushing while monitoring the amount of toothpaste used by the client, providing directives to the client to prevent overbrushing (after client #4's gums started to bleed), and ensuring client #4 put the toothpaste in his hygiene basket after use. Interview with group home staff A on 8/4/21 revealed client #4 no longer has hygiene items	{W 288}		

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{W 288}	Continued From page 5	{W 288}		

locked in the medication room and the client keeps all items in his bedroom. Continued interview with staff A revealed client #4 continues to misuse hygiene items by using inappropriate amounts and throwing items away. Further interview with staff A revealed client #4 also enters the bedrooms of housemates and steals hygiene items which upsets other clients. Additional interview with staff A revealed no additional intervention or program had been implemented to address client #4's misuse of hygiene items other than to allow the client access to his hygiene items rather than keeping items locked in the medication room.

Interview with staff B on 8/4/21 revealed she had provided client #4 a new tube of toothpaste on the current morning and client #4 indicated he threw it away.

Review of records for client #4 on 8/4/21 revealed a behavior support plan (BSP) dated 11/12/20, as reviewed with the 4/22/21 survey. Continued review of records revealed no update to the 11/12/20 BSP for client #4 and target behaviors to remain identified as: physical aggression, social isolation, inappropriate food acquisition and property destruction.

Further record review for client #4 revealed a psychology note dated 5/26/21. Review of the 5/2021 psychology note revealed client #4 is still taking personal hygiene items from others; It was recommended by the team that staff buy travel size items and then refill as needed so if the client uses all the bottle it is not an excessive amount. A review of in-service trainings with staff revealed no evidence staff were trained relative to the team recommendation referenced in the 5/2021

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{W 288}	Continued From page 6 psychology note. Interview with clinical staff and the facility psychologist verified client #4 should be provided travel size hygiene items to address the current identified behavior of inappropriate use of hygiene items. Continued interview with clinical staff verified client #4's behavior of misusing/throwing away hygiene items had not been added to the behavior support plan. Further interview with clinical staff revealed staff should not be providing client #4 with full size hygiene items. Subsequent interview with clinical staff verified there was no evidence of an in-service training with staff regarding the use of trial size hygiene items as an intervention to address client #4's behavior related to hygiene items.	{W 288}		