PRINTED: 05/04/2022 FORM APPROVED OMB NO. 0938-0391

MANE OF PROVIDER OR SUPPLIER LAGRANGE HOME SUMMANY STATEMENT OF DESIDENCIES BY THE LAGRANGE, NO. 28551 LAGRANGE HOME SUMMANY STATEMENT OF DESIDENCIES BY THE LAGRANGE, NO. 28551 LAGRANGE, NO. 28	` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
A65 WEST WASHINGTON STREET LA GRANGE, NC 28561			34G171	B. WING			05	5/03/2022
PREFIX TAG REGULATORY OR LSC IDENTRYING INFORMATION) E 030 Names and Contact Information CFR(s): 483.475(c)(1) \$440.748(c)(1), \$416.54(c)(1), \$418.113(c)(1), \$441.148(c)(1), \$484.52(c)(1), \$483.475(c)(1) \$441.184(c)(1), \$460.84(c)(1), \$482.15(c)(1), \$483.475(c)(1), \$483.5(c)(1), \$483.5(c)(1					405 V	VEST WASHINGTON STREET	·	
CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §485.84(c)(1), §484.102(c)(1), §485.92(c)(1), §485.625(c)(1), §485.727(c)(1), §485.92(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. "[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (1) Names and contact information for the following: (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [fospitals and CAHs]. (v) Volunteers.	PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETION
following: ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		CFR(s): 483.475(c) §403.748(c)(1), §44 §441.184(c)(1), §48 §483.73(c)(1), §48 §485.68(c)(1), §48 §494.62(c)(1). [(c) The [facility mu emergency prepare that complies with Fand must be review 2 years [annually focommunication platfollowing:] (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Patients' physic (iv) Other [facilities] (v) Volunteers. *[For Hospitals at § §485.625(c)] The coinclude all of the fol (1) Names and confollowing: (i) Staff. (ii) Entities providin (iii) Patients' physic (iv) Other [hospitals (v) Volunteers. *[For RNHCIs at §4 communication platfollowing:	16.54(c)(1), §418.113(c)(1), 60.84(c)(1), §482.15(c)(1), 3.475(c)(1), §484.102(c)(1), 15.625(c)(1), §485.727(c)(1), 16.360(c)(1), §491.12(c)(1), 17.5625(c)(1), §491.12(c)(1), 18.5625(c)(1), §491.12(c)(1), 19.5625(c)(1), 19.5625(c)(1), 19.5625(c)(1), §491.12(c)(1), 19.5625(c)(1), 19.5625(c)(030			

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		34G171	B. WING		05/9	03/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 030	following: (i) Staff. (ii) Entities providing (iii) Next of kin, guar (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416. plan must include al (1) Names and cont following: (i) Staff. (ii) Entities providing (iii) Patients' physici (iv) Volunteers. *[For Hospices at §4 communication plan following: (1) Names and cont following: (1) Names and cont following: (i) Hospice employe (ii) Entities providing (iii) Patients' physici (iv) Other hospices. *[For HHAs at §484 plan must include al (1) Names and cont following: (i) Staff. (ii) Entities providing (iii) Patients' physici (iii) Patients' physici (iv) Volunteers.	g services under arrangement. rdian, or custodian. 45(c):] The communication If of the following: ract information for the g services under arrangement. ans. 418.113(c):] The must include all of the ract information for the res. g services under arrangement. ans. 102(c):] The communication If of the following: ract information for the g services under arrangement. ans. 102(c):] The communication If of the following: ract information for the g services under arrangement. ans.	E 03	30			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	IPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
		34G171	B. WING _			05/03/2022
NAME OF PE	ROVIDER OR SUPPLIER		,	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 039	following: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and do Donation Service Are This STANDARD is Based on document facility failed to ensu preparedness (EP) of developed and main Federal, State and local Review on 5/2/22 of (EP) dated 1/15/202 management director direct care staff to comergency. Further the names and phonicare staff who no long facility. Additional revintellectual disabilitie ICF/IDD program director revibeen updated since EP Testing Requirem CFR(s): 483.475(d)(2), §416.54(d)(2), §418.	services under arrangement. conor hospitals in the OPO's ea (DSA). not met as evidenced by: creview and interview, the re an emergency communication plan was tained in compliance with local laws. The finding is: the facility's emergency plant revealed a staff list with rs and phone numbers for contact in the event of an review of this list revealed e numbers of several direct ager were employed by the view revealed the qualified is professional (QIDP) and ector who are newly ested in the facility's EP. with the facility's ICF/IID ealed the facility's EP had not 1/15/2021. ments		039		
		4.102(d)(2), §485.68(d)(2), 5.727(d)(2), §485.920(d)(2), 62(d)(2).				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G171	B. WING		05/03/2022	
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	·	
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E 039	"Organizations" unde §485.920, RHCs/FQ Facilities at §494.62] (2) Testing. The [facility to test the emergence must do all of the following for the followi	54, CORFs at §485.68, OPO, er §485.727, CMHCs at HCs at §491.12, and ESRD: lity] must conduct exercises y plan annually. The [facility] owing: I-scale exercise that is very 2 years; or nity-based exercise is not a facility-based functional	E 03	9		
	years, opposite the y functional exercise us this section is condumot limited to the followard (A) A second full-scatter community-based or functional exercise; (B) A mock disaster (C) A tabletop exercial a facilitator and incluant an arrated, clinically scenario, and a set of directed messages, designed to challeng	nder paragraph (d)(2)(i) of cted, that may include, but is owing: ale exercise that is individual, facility-based or drill; or se or workshop that is led by des a group discussion using				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		34G171	B. WING		l c	5/03/2022
NAME OF P	ROVIDER OR SUPPLIER	,	,	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
E 039	exercises, and emerge [facility's] emergency *[For Hospices at 413 (2) Testing for hospic patient's home. The exercises to test the annually. The hospic (i) Participate in a further community based ev (A) When a communaccessible, conduct a functional exercise et (B) If the hospice exprannmade emergency plan, engaging in its next recommunity-based expacility-based function onset of the emerger (ii) Conduct an addit opposite the year the exercise under paragis conducted, that may to the following: (A) A second full-sca community-based or exercise; or (B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, clinically-scenario, and a set of directed messages, of designed to challenge.	gency events, and revise the plan, as needed. 3.113(d):] Des that provide care in the hospice must conduct emergency plan at least be must do the following: Ill-scale exercise that is ery 2 years; or eity based exercise is not an individual facility based every 2 years; or eriences a natural or experiences a natural or experiences a natural or equired full scale ercise or individual nal exercise following the ercise or individual nal exercise following the ercy event. It ional exercise every 2 years, a full-scale or functional exercise following the ercy event. In all exercise that is a facility based functional exercise that is a facility based functional drill; or exercise or workshop that is led by does a group discussion using	E 03	39		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G171	B. WING		05/03/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	1 00000	
(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 CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION	
E 039	exercises to test the year. The hospice r (i) Participate in an is community-based (A) When a communaccessible, conduct facility-based function (B) If the hospice eximan-made emergenthe emergency planengaging in its next based or facility-based following the onset of (ii) Conduct an addit may include, but is r (A) A second full-socommunity-based or exercise; or (B) A mock disaster (C) A tabletop exercise facilitator that including narrated, clinically-reand a set of problem messages, or prepare challenge an emergination of the problem in th	ospice must conduct emergency plan twice per nust do the following: annual full-scale exercise that ; or nity-based exercise is not an annual individual onal exercise; or periences a natural or toy that requires activation of the hospice is exempt from required full-scale community ed functional exercise of the emergency event. Itional annual exercise that not limited to the following: tale exercise that is r a facility based functional r drill; or cise or workshop led by a tes a group discussion using a televant emergency scenario, a statements, directed red questions designed to tency plan. Topice's response to and tition of all drills, tabletop regency events and revise the ty plan, as needed. 1.184(d), Hospitals at	E 03	9		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	7 00/00/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPROPRIES OF	JLD BE COMPLETION	
E 039	is community-based; (A) When a commun accessible, conduct a facility-based function (B) If the [PRTF, Hos actual natural or mar requires activation of [facility] is exempt from required full-scale confacility-based function onset of the emerger (ii) Conduct and and that may include following: (A) A second full-scale confunctional exercise; (B) A mock (C) A tabletop existed by a facilitator and discussion, using a nemergency scenario, statements, directed questions designed to plan. (iii) Analyze the maintain documentate exercises, and emergency facility's] emergency *[For PACE at §460.8] (2) Testing. The PAC exercises to test the annually. The PACE following:	annual full-scale exercise that or ity-based exercise is not an annual individual, hal exercise; or spital, CAH] experiences an annual exercise; or spital, CAH] experiences an annual exercise or the emergency plan, the sime engaging in its next mmunity based or individual, hal exercise following the exercise following the exercise that is individual, a facility-based or disaster drill; or exercise or workshop that is dincludes a group arrated, clinically-relevant and a set of problem messages, or prepared to challenge an emergency [facility's] response to and ion of all drills, tabletop gency events and revise the plan, as needed. [34(d):] E organization must conduct emergency plan at least organization must do the annual full-scale exercise that	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		34G171	B. WING _			05/03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	,	
(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 CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
E 039	accessible, conduct facility-based function (B) If the PACE expension man-made emerger the emergency plan engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the yexercise under parais conducted that materials the following: (A) A second full-second full-second functional exercise; (B) A mock disaster (C) A tabletop exercial facilitator and inclusing a narrated, cliscenario, and a set directed messages, designed to challency (iii) Analyze the PAmaintain documentate exercises, and emerphace (2) The [LTC facility test the emergency including unannouncemergency procedured in the exercise of the emergency including unannouncemergency procedured in the exercise of the emergency including unannouncemergency procedured in the exercise of the emergency procedured in the emergency proced	nity-based exercise is not an annual individual, onal exercise; or eriences an actual natural or not that requires activation of the PACE is exempt from required full-scale community facility-based functional the onset of the emergency additional exercise every 2 rear the full-scale or functional graph (d)(2)(i) of this section and include, but is not limited to real exercise that is a individual, a facility based for a drill; or cise or workshop that is led by undes a group discussion, inically-relevant emergency of problem statements, or prepared questions are an emergency plan. CE's response to and aution of all drills, tabletop regency events and revise the plan, as needed. Let §483.73(d):] I must conduct exercises to plan at least twice per year, and staff drills using the res. The [LTC facility, and following: annual full-scale exercise that	EO	39		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED		
		34G171	B. WING		l c	5/03/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
E 039	accessible, conduct a facility-based function (B) If the [LTC facility actual natural or mar requires activation of LTC facility is exemp required a full-scale of individual, facility-based following the onset of (ii) Conduct an addit may include, but is not (A) A second full-scale community-based or functional exercise; of (B) A mock disaster (C) A tabletop exercial facilitator includes a narrated, clinically-reand a set of problem messages, or prepar challenge an emerge (iii) Analyze the [LTC and maintain docume exercises, and emerge [LTC facility] facility's *[For ICF/IIDs at §48 (2) Testing. The ICF/to test the emergency The ICF/IID must do (i) Participate in an an is community-based; (A) When a community-based; (A) When a community-based function (B) If the ICF/IID exp	ity-based exercise is not an annual individual, nal exercise.] facility experiences an annual exercise an annual exercise an annual exercise an annual exercise and annual exercise and annual exercise and annual exercise that an individual, facility based or dill; or a an individual, directed expected and revise the emergency plan, as needed. 3.4.75(d)]: IID must conduct exercises and revise the emergency plan, as needed. 3.4.75(d)]: IID must conduct exercises and revise the emergency plan at least twice per year. The following: Innual full-scale exercise that or annual individual,	E 03	39			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G171	B. WING			05/03/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 405 WEST WASHINGTON STREET LA GRANGE, NC 28551		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
E 039	engaging in its next recommunity-based or functional exercise for emergency event. (ii) Conduct an additismay include, but is not a second full-scat community-based or functional exercise; of the community-based or the community-based; of the emergency lengaging in its next recommunity-based or functional exercises, and emerging the emergency lengaging in its next recommunity-based or functional exercises.	the ICF/IID is exempt from required full-scale individual, facility-based ollowing the onset of the conal annual exercise that of limited to the following: le exercise that is an individual, facility-based or drill; or see or workshop that is led by des a group discussion, ideally-relevant emergency of problem statements, or prepared questions e an emergency plan. IID's response to and dion of all drills, tabletop gency events, and revise the plan, as needed. 102] HA must conduct exercises y plan at the must do the following: I-scale exercise that is remunity-based exercise is not an annual individual, anal exercise every 2 years; experiences an actual natural ency that requires activation and, the HHA is exempt from	E 03	9		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G171	B. WING			05/	03/2022
NAME OF PI	ROVIDER OR SUPPLIER			4	STREET ADDRESS, CITY, STATE, ZIP CODE 105 WEST WASHINGTON STREET LA GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	opposite the year the exercise under paragis conducted, that limited to the following (A) A second full-community-based or functional exercise; o (B) A mock disass (C) A tabletop ex led by a facilitator and discussion, using a nate mergency scenario, statements, directed a questions designed to plan. (iii) Analyze the HHA' documentation of all demergency events, all emergency plan, as not emergency graphs, and discussion, using a nate mergency scenario, statements, directed and discussion, using a nate mergency scenario, statements, directed and questions designed to plan. If the OPO experimental emergency plan, engaging in its next respective.	onal exercise every 2 years, full-scale or functional raph (d)(2)(i) of this section that may include, but is not g: -scale exercise that is an individual, facility-based rater drill; or ercise or workshop that is dincludes a group exarted, clinically-relevant and a set of problem messages, or prepared or challenge an emergency as response to and maintain drills, tabletop exercises, and and revise the HHA's needed. 660] PO must conduct exercises or plan. The OPO must do the eased, tabletop exercise is dincludes a group exercise is dincludes a group exercised, clinically relevant.	E	039			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		34G171	B. WING _			05/03/2022	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	=		
(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 COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 039	(ii) Analyze the OPC documentation of all emergency events, OPO's] emergency *[RNCHIs at §403.7 (d)(2) Testing. The F exercises to test the must do the followin (i) Conduct a paperleast annually. A tab discussion led by a clinically-relevant er of problem statemer prepared questions emergency plan. (ii) Analyze the RNF maintain documenta and emergency eve emergency plan, as This STANDARD is Based on record re failed to ensure a fa tabletop exercise was emergency plan. The Review on 5/2/22 of (EP) dated 1/5/2021 information regardin exercise or tabletop possible emergency facility's EP. Interview on 5/3/22 director revealed the available to substan based or tabletop exercise or substantal pased or substan	D's response to and maintain tabletop exercises, and and revise the [RNHCl's and plan, as needed. 748]: RNHCl must conduct emergency plan. The RNHCl g: based, tabletop exercise at pletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ants, directed messages, or designed to challenge an action of all tabletop exercises, and revise the RNHCl's needed. not met as evidenced by: view and interview, the facility collity/community-based or as conducted to test their nee finding is: the facility's emergency plan did not reveal any g either a community based exercise to implement scenarios as defined in the with the ICF/IID program ere was not any information tiate that either a community	EO	39			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G171	B. WING			05/	03/2022
NAME OF PROVIDER OR SUPPLIER LAGRANGE HOME				4	TREET ADDRESS, CITY, STATE, ZIP CODE 05 WEST WASHINGTON STREET A GRANGE, NC 28551	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE
W 340 W 340	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			340			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER LAGRANGE HOME				STREET ADDRESS, CITY, STATE, ZIP C 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	ODE		
(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 ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
W 340	COVID-19 policy rega vaccinations for staff include specific inform of personal protective Review on 5/3/22 of N of Health and Human on Mask Guidance ef " Masks are still requi	arding COVID-19 dated 1/24/22 did not nation regarding the wearing equipment. North Carolina Department Services(NCDHHS) policy fective date 3/7/22 revealed, red in places like health are. This is because of the	W	340			