## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2022 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  LAURA SPRINGS ROAD HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPTICENCY MUST BE PRACEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 263  PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)  The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility falled to ensure that written informed consents were obtained prior to implementation of a restrictive procedure for 5 of 6 clients. The finding is:  Observation in the group home throughout survey on 0/28/22 from 4:00 PM-8:00 PM revealed 6 of 6 clients to participate in a dinner meal of chicken and rice, mixed vegetables, jello with fruit, apple sauce, Kool-Aid, milk and water. Continued observation revealed staff to access the pantry room using an electronic keypad to unlock the door that was inaccessible to all clients.  Observation in the group home throughout survey on 6/29/22 from 6:30 AM-9:00 AM revealed 6 of 6 clients to participate in medication administration for which some required use of apple sauce, pudding or yogurt to take medications. Continue observation revealed staff D to access the pantry room using an electronic keypad to unlock the door that was inaccessible to all clients.  Review of records for client #4 on 6/29/22 revealed a person-centered plan (PCP) dated 2/5/22. Continued review of the record revealed a behavior support plan (BSP) dated 5/18/22. Review of the BSP revealed target behaviors of	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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PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  ROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  W 263  PROGRAM MONITORING & CHANGE  CFR(s): 483.440(f)(3)(ii)  The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.  This STANDARD is not met as evidenced by: Based on observation, record review and interviews, the facility failed to ensure that written informed consents were obtained prior to implementation of a restrictive procedure for 5 of 6 clients. The finding is:  Observation in the group home throughout survey on 6/28/22 from 4:00 PM-6:00 PM revealed 6 of 6 clients to participate in a dinner meal of chicken and rice, mixed vegetables, jello with fruit, apple sauce, Kool-Aid, milk and water. Continued observation revealed staff to access the pantry room using an electronic keypad to unlock the door that was inaccessible to all clients.  Observation in the group home throughout survey on 6/28/22 from 6:30 AM-9:00 AM revealed 6 of 6 clients to participate in medication administration for which some required use of apple sauce, pudding or yogurt to take medications. Continue observation revealed staff D to access the pantry room using an electronic keypad to unlock the door that was inaccessible to all clients.  Review of records for client #4 on 6/29/22 revealed a person-centered plan (PCP) dated 2/5/22. Continued review of the record revealed a behavior support plan (BSP) dated 5/18/22.  Review of the BSP revealed target behaviors of					309 L	AURA SPRINGS DR	•	
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physical aggression, social isolation, inappropriate food acquisition, property destruction, misusing hygiene products,  LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE		CFR(s): 483.440(f). The committee sho are conducted only consent of the clien minor) or legal guar This STANDARD is Based on observation interviews, the facili informed consents implementation of a 6 clients. The findin Observation in the on 6/28/22 from 4:00 clients to participate and rice, mixed veg sauce, Kool-Aid, mobservation revealer oom using an election door that was inaction of 6/29/22 from 6:30 clients to participate for which some required pudding or yogurt to observation revealer oom using an election using an election of 6/29/22. Continued revealed a person-2/5/22. Continued rephysical aggression inappropriate food a destruction, misusing and struction, misusing and struction of the destruction, misusing and struction of the significant of the signif	could insure that these programs with the written informed at, parents (if the client is a rdian. It is not met as evidenced by: tion, record review and ity failed to ensure that written were obtained prior to a restrictive procedure for 5 of ang is:  In group home throughout survey 20 PM-6:00 PM revealed 6 of 6 in a dinner meal of chicken getables, jello with fruit, apple ilk and water. Continued at staff to access the pantry tronic keypad to unlock the cessible to all clients.  In group home throughout survey and AM-9:00 AM revealed 6 of 6 in medication administration uired use of apple sauce, to take medications. Continue at staff D to access the pantry tronic keypad to unlock the cessible to all clients.  For client #4 on 6/29/22 centered plan (PCP) dated eview of the record revealed a an (BSP) dated 5/18/22. revealed target behaviors of an social isolation, acquisition, property and hygiene products,		263			

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G051	B. WING		06/	06/29/2022	
NAME OF PROVIDER OR SUPPLIER  LAURA SPRINGS ROAD HOME				STREET ADDRESS, CITY, STATE 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)			PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
W 263	noncompliance, very property. Further results Human Rights Comwhich indicated a compantry door, door collocked bedroom clocked bedroom clocked bedroom clocked and snacks times to prevent activate on 6/29/2 disabilities profession interventions in the Continued interview #4 does have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #3, #5 and #6 do not which we have a correstricted access to #40.	rbal disruptions and taking eview of the record revealed a mittee approval dated 1/11/22 onsent for locking of the himes on bedroom door and oset. Review of records for 45 and #6 revealed no 1/10 to be kept distributed at designated	W 2	63			