DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/04/2022 FORM APPROVED

		CENTERS F	OR MEDICARE & MEDICAID SERVIC	ES OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DAT COMPL	TE SURVEY ETED
	34G171	B. WING		05/	03/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAGRANGE HOME			405 WEST WASHINGTON STREET LA GRANGE, NC 28551		
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICENCY)	D BE	(X5) COMPLETION DATE
§483.475(c)(1), §488 §485.68(c)(1), §485 §485.727(c)(1), §485 §486.360(c)(1), §495 §494.62(c)(1). [(c) The [facility must emergency prepared that complies with Flaws and must be releast every 2 years. The communication plant the following: (1) Names and contifollowing: (i) Staff. (ii) Entities providing arrangement. (iii) Pacific (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §45485.625(c)] The commust include all of the second continuation plant the facilities].	6.54(c)(1), 1.184(c)(1), 1.15(c)(1), 1.5(c)(1), 1.625(c)(1), 1.12(c)(1), 1.12(E 030	Emergency preparedness communication has been been updated with nation that complies with Federal, State, and local laws.	mes and	

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

Carol Walters, Program Director 5/12/22

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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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:TLTO11 Facility ID: 922264 If continuation sheet Page 1 of 14
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ 34G171 B. WING_ 05/03/2022 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **405 WEST WASHINGTON STREET LAGRANGE HOME** LA GRANGE, NC 28551 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY)

9197357207 Nova Suite G 11:33:40 a.m. 05–12–2022 7 /20

E 030 Continued From page 1 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Votunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospicas at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (v) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (1) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (iv) Volunteers.				
(ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The	E 030	(1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(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:	E 030	
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(ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The				
(iv) Volunteers. *[For OPOs at §486.360(c):] The		(ii) Entities providing services under		
*[For OPOs at §486.360(c):] The				
		(iv) Volunteers.		
following:		communication plan must include all of the		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

			Omit i bitt	STOR MEDICARE & MEDICAID SERVI	<u>020 0180 110, 0000-00;</u>
' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		34G171	B. WIN	3	05/03/2022
NAME OF PR	OVIDER OR SUPPLIER E HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION

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		1	T	· · · · · · · · · · · · · · · · · · ·
E 030	Continued From page 2	E 030		
	(2) Names and contact information for the			
	following:			
	(i) Staff.			
	(ii) Entities providing services under	1		
	arrangement. (iii) Volunteers.			
	(iv) Other OPOs.			
	(v) Transplant and donor hospitals in the			
	OPO's Donation Service Area (DSA).			
	This STANDARD is not met as evidenced			ļ i
	by: Based on document review and			
	interview, the facility failed to ensure an			
	emergency			
	preparedness (EP) communication plan			
	was developed and maintained in			
	compliance with Federal, State and local laws. The finding is:			
	iaws. The initiality is.			
	Review on 5/2/22 of the facility's emergency			
	plan (EP) dated 1/15/2021 revealed a staff list			
	with management directors and phone	İ		
	numbers for direct care staff to contact in the			
	event of an emergency. Further review of this			
	list revealed the names and phone numbers			
	of several direct care staff who no longer			
	were employed by the facility. Additional review revealed the qualified intellectual			
	disabilities professional (QIDP) and ICF/IDD	į		
	program director who are newly	***************************************		
	employed were not listed in the facility's EP.	****		
	and the same of th			
E 039	Interview on 5/3/22 with the facility's ICF/IID	E 039	The Facility Support Coordinator will review	
	program director revealed the facility's EP had		the schedule for the evacuation drills to	
	not been updated since 1/15/2021.		ensure varied times and conditions are noted.	[
	EP Testing Requirements		QP/RSS will post evacuation drill times in the	
	CFR(s): 483.475(d)(2)		home.Habilitation Technician staff will be	
	\$445 E4/4\\0\ \$440 A40\/4\\0\		inserviced on the drills in compliance with th	
	§416.54(d)(2), §418.113(d)(2),		schedule posted.	
	§441.184(d)(2), §460.84(d)(2),			
	§482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2),			
	§485.68(d)(2), §485.625(d)(2),			
	§485.727(d)(2), §485.920(d)(2),			
	§491.12(d)(2), §494.62(d)(2).			
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

			CENTERS	FOR MEDICARE & MEDICAID SERVICES	OMB NO	. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · · · · · · · · · · · · · · · · · ·		(X3) DATE COMPLE	SURVEY TED
		34G171	B. WING		05/0	3/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE

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			DEFICIENCY)	
E 039	Continued From page 3	E 039		
	*[For ASCs at §416.54, CORFs at §485.68,	-		
	OPO, "Organizations" under §485.727,			3
	CMHCs at §485.920, RHCs/FQHCs at			
	§491.12, and ESRD Facilities at §494.62]:			
	(2) Testing. The [facility] must conduct			
- 1	exercises to test the emergency plan annually.			İ
	The [facility] must do all of the following:			
	(i) Participate in a full-scale exercise that			
	is community-based every 2 years; or			
	(A) When a community-based exercise is			
	not accessible, conduct a facility-based			Ì
	functional exercise every 2 years; or			
	(B) If the [facility] experiences an actual			
	natural or man-made emergency that			
	requires activation of the emergency plan,			
ĺ	the [facility] is exempt from engaging in its next required			
	community-based or individual,			
	facility-based functional exercise following			
	the onset of the actual event.			
	(ii) Conduct an additional exercise at least	:		
	every 2 years, opposite the year the full-scale			
	or			
	functional exercise under paragraph (d)(2)(i) of			
	this section is conducted, that may include, but			
	is not limited to the following:			
	(A) A second full-scale exercise that is			
	community-based or individual,			
	facility-based functional exercise; or			
	(B) A mock disaster drill; or			
	(C) A tabletop exercise or workshop that is led			
	by a facilitator and includes a group discussion			
	using a narrated, clinically-relevant emergency			
	scenario, and a set of problem			
	statements, directed messages, or			
	prepared questions			
Ì	designed to challenge an emergency plan.			
	(iii) Analyze the [facility's] response to and			1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

			ENTER	FOR MEDICARE & MEDICAID SERVICES	OMB NO). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY ETEO
		34G171	B. WIN	G	05/0	03/2022
., =	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIA		(X5) COMPLETION DATE

DEFICIENCY)

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E 039	Continued From page 4	E 039	
	maintain documentation of all drills, tabletop		
	exercises, and emergency events, and revise		
	the [facility's] emergency plan, as needed.		
	*[For Hospices at 418.113(d):]		
	(2) Testing for hospices that provide care in		
	the patient's home. The hospice must		
	conduct exercises to test the emergency		
	plan at least annually. The hospice must do		
	the following: (i) Participate in a full-scale		
	exercise that is community based every 2		
	years; or		
	(A) When a community based exercise is		
	not accessible, conduct an individual facility		
]	based functional exercise every 2 years; or		
]	(B) If the hospice experiences a natural or		
	man-made emergency that requires activation		
	of the emergency plan, the hospital is exempt		
	from engaging in its next required full scale		
	community-based exercise or individual		
	facility-based functional exercise following		
	the onset of the emergency event.		
	(ii) Conduct an additional exercise every 2		
	years, opposite the year the full-scale or		
	functional exercise under paragraph (d)(2)(i) of		
1	this section is conducted, that may include,		
	but is not limited to the following:		
	(A) A second full-scale exercise that is		
	community-based or a facility based		
	functional exercise; or		
	(B) A mock disaster drill; or		
	(C) A tabletop exercise or workshop that is led		
	by a facilitator and includes a group discussion		
	using a narrated, clinically-relevant emergency	1	
	scenario, and a set of problem		
	statements, directed messages, or		
	prepared questions	1	
	designed to challenge an emergency plan.		
	(3) Testing for hospices that provide inpatient		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	TIPLE CONSTRUCTI	ON	(X3) DAT	E SURVEY ETED
		34G171	B. WIN			05/	03/2022
	PROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE HINGTON STREET NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE

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E 039	Continued From page 5	E 039		
	care directly. The hospice must conduct		[
	exercises to test the emergency plan twice			
	per year. The hospice must do the			
	following:			
	(i) Participate in an annual full-scale exercise	-		
	that is community-based; or		<u> </u>	
	(A) When a community-based exercise is			
	not accessible, conduct an annual			
	individual			
	facility-based functional exercise; or			
	(B) If the hospice experiences a natural or			
	man-made emergency that requires activation			
	of the emergency plan, the hospice is exempt			
	from engaging in its next required full-scale			
	community based or facility-based functional			
	exercise		and the state of t	
	following the onset of the emergency event.			
	(ii) Conduct an additional annual exercise			
	that may include, but is not limited to the			
	following: (A) A second full-scale exercise			
	that is			
	community-based or a facility based			
	functional exercise; or			
	(B) A mock disaster drill; or			
	(C) A tabletop exercise or workshop led by a			
	facilitator that includes a group discussion			
	using a narrated, clinically-relevant emergency			
	scenario, and a set of problem statements,	***		
	directed	***************************************		
	messages, or prepared questions designed			
	to challenge an emergency plan.	***		
	(iii) Analyze the hospice's response to and			
	maintain documentation of all drills, tabletop			
	exercises, and emergency events and revise			
	the hospice's emergency plan, as needed.			
	*[For PRFTs at §441.184(d), Hospitals at			
	§482.15(d), CAHs at §485.625(d):]			
	(2) Testing. The [PRTF, Hospital, CAH] must	1		
	conduct exercises to test the emergency plan			
	twice per year. The [PRTF, Hospital, CAH]			
	must do the following:	1		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		34G171	B. WIN	G		05/03/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 405 WEST WASHINGTON STREE LA GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETION DATE

		***************************************	DEFICIENCY)	
E 039	Continued From page 6	E 039		
	(i) Participate in an annual full-scale exercise	1		
	that is community-based; or			
	(A) When a community-based exercise is			
	not accessible, conduct an annual			
	individual,			
	facility-based functional exercise; or			
	(B) If the [PRTF, Hospital, CAH] experiences			
	an actual natural or man-made emergency			
	that requires activation of the emergency plan,			
	the [facility] is exempt from engaging in its			
	next required full-scale community based or			
	individual, facility-based functional exercise			
	following the onset of the emergency event.			
	(ii) Conduct an [additional] annual exercise			
	or and that may include, but is not limited to the			ł
	following:			
İ	(A) A second full-scale exercise that is			
	community-based or individual, a	i i		
	facility-based functional exercise; or (B) A mock disaster drill; or			
	(C) A tabletop exercise or workshop that is			
	·			
	led by a facilitator and includes a group discussion, using a narrated,			
	clinically-relevant emergency scenario, and			
	a set of problem			
	statements, directed messages, or prepared			İ
	questions designed to challenge an			
	emergency plan.			
	(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.			
Ì	, , , , , , , , , , , , , , , , , , ,			
	*[For PACE at §460.84(d):]			
ŀ	(2) Testing. The PACE organization must			
	conduct exercises to test the emergency plan			
-	at least annually. The PACE organization must			
I	do the following:			
	(i) Participate in an annual full-scale exercise			
	that is community-based; or			1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	DING	(X3) DATE SURVEY COMPLETED
		34G171	B. WIN	3	05/03/2022
NAME OF PROVIDER OR SUPPLIER LAGRANGE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·

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E 039	Continued From page 7	E 039	
	(A) When a community-based exercise is		
	not accessible, conduct an annual		
	individual,		
	facility-based functional exercise; or		
	(B) If the PACE experiences an actual natural	İ	
	or man-made emergency that requires		
	activation of the emergency plan, the PACE is		
	exempt from engaging in its next required		
	full-scale community based or individual,		
	facility-based functional exercise following the		
	onset of the emergency event.		
	(ii) Conduct an additional exercise every 2		
	years opposite the year the full-scale or		
	functional exercise under paragraph (d)(2)(i) of		
	this section is conducted that may include, but		
	is not limited to the following: (A) A second full-scale exercise that is	1	
	community-based or individual, a facility		
	based functional exercise; or	1	
	(B) A mock disaster drill; or	1	
	(C) A tabletop exercise or workshop that is led		
	by a facilitator and includes a group		
	discussion, using a narrated, clinically-relevant	***************************************	
	emergency scenario, and a set of problem		
	statements, directed messages, or prepared		
	questions	***************************************	
	designed to challenge an emergency plan.	***************************************	
	(iii) Analyze the PACE's response to and	İ	
	maintain documentation of all drills, tabletop	Ì	
	exercises, and emergency events and revise		
	the PACE's emergency plan, as needed.		
	*[For LTC Facilities at §483.73(d):]		
	(2) The [LTC facility] must conduct exercises		
	to test the emergency plan at least twice per		
	year, including unannounced staff drills		
	using the emergency procedures. The [LTC		
	facility,		
	ICF/IID] must do the following:		
	(i) Participate in an annual full-scale exercise		
	that is community-based; or		

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PRINTED: 05/04/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391
(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

1	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DA COMPI	TE SURVEY .ETED
		34G171	B. WING	i	05	/03/2022
NAME OF PI	ROVIDER OR SUPPLIER SE HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET LA GRANGE, NC 28551		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE

9197357207 Nova Suite G 11:37:54 a.m. 05–12–2022 14 /20

E 039	Continued From page 8	E 039	
	(A) When a community-based exercise is		***
	not accessible, conduct an annual		
	individual,		İ
	facility-based functional exercise.		
	(B) If the [LTC facility] facility experiences	right and the second se	
	an actual natural or man-made emergency	-	
	that requires activation of the emergency		[
	plan, the LTC facility is exempt from		į
	engaging its next required a full-scale		
	community-based or		
	individual, facility-based functional exercise	ĺ	
	following the onset of the emergency event.		
	(ii) Conduct an additional annual exercise		
	that may include, but is not limited to the		
	following: (A) A second full-scale exercise		
	that is		
	community-based or an individual, facility	***************************************	
	based functional exercise; or		
	(B) A mock disaster drill; or		
	(C) A tabletop exercise or workshop that is led		
	by a facilitator includes a group discussion,		
	using a narrated, clinically-relevant emergency		
	scenario, and a set of problem statements,		AF
	directed		
	messages, or prepared questions designed		
	to challenge an emergency plan.		
	(iii) Analyze the [LTC facility] facility's response		
	to and maintain documentation of all drills,		
	tabletop exercises, and emergency events,		
	and revise the [LTC facility] facility's		
	emergency plan, as needed.		
	*[For ICF/IIDs at §483.475(d)]:		
	(2) Testing. The ICF/IID must conduct exercises		
	to test the emergency plan at least twice per		
	year. The ICF/IID must do the following:		
	(i) Participate in an annual full-scale exercise		
	that is community-based; or		
	(A) When a community-based exercise is		
	not accessible, conduct an annual		
	individual,		
	facility-based functional exercise; or.	1	
	(B) If the ICF/IID experiences an actual natural		
	or man-made emergency that requires	1	
	activation of		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G171	(X2) ML A. BUIL B. WIN		(X3) DATE SURVEY COMPLETED 05/03/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAGRANGE HOME			405 WEST WASHINGTON STREET LA GRANGE, NC 28551	

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Nova Suite G 11:38:29 a.m. 05–12–2022

15 /20

(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 039	the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency plan, as needed.	E 039		
	*[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	34G171	B. WIN	G	05/03/2022
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LAGRANGE HOME			405 WEST WASHINGTON STREET	
			LA GRANGE, NC 28551	

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11:39:06 a.m. 05-12-2022

16 /20

(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 039	Continued From page 10 emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.	E 039		
	*[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event.			

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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
	34G171	B. WING	05/03/2022
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 405 WEST WASHINGTON STREET	
I AGRANGE HOME		405 WEST WASHINGTON STREET	

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			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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 11	E 039		
	(ii) Analyze the 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.			
	*[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI 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 response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a facility/community-based or tabletop exercise was conducted to test their emergency plan. The finding is:			
	Review on 5/2/22 of the facility's emergency plan (EP) dated 1/5/2021 did not reveal any information regarding either a community based exercise or tabletop exercise to implement possible emergency scenarios as defined in the facility's EP. Interview on 5/3/22 with the ICF/IID program			
	director revealed there was not any information available to substantiate that either a community based or tabletop exercise had been implemented during the past program year.			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	34G171	B. WING	05/03/2022

Nova Suite G 11:40:18 a.m. 05–12–2022

18 /20

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **405 WEST WASHINGTON STREET LAGRANGE HOME** LA GRANGE, NC 28551 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 340 W 340 Continued From page 12 W 340 W 340 **NURSING SERVICES** CFR(s): 483.460(c)(5)(i) QP/RSS will inservice habilitations technician Nursing services must include implementing with other members of the interdisciplinary staff on the appropriate protective and team, appropriate protective and preventive preventive health measures that include, but health measures that include, but are not are not limited to, training clients and staff as limited to training clients and staff as needed needed in appropriate health and hygiene in appropriate health and hygiene methods. methods. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure nursing staff sufficiently trained direct care staff regarding appropriate nursing practices and protocols. This potentially affected 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding During observations in the facility on 5/3/22 staff C met the surveyor at the front door at 6:00am not wearing a facial mask. Throughout observations he worked with all six clients helping them with dressing, leisure and grooming not wearing a facial mask. Staff C departed the home on 5/3/22 at 6:52am. Interview on 5/3/22 with the residential manager (RM) regarding the wearing of facial masks in facilities revealed residential staff were told the company is continuing to follow Centers for Disease Control (CDC) guidance regarding COVID-19 prevention. When asked if residential staff are mandated to wear masks, the RM stated," If they are vaccinated, I don't think so." Interview on 5/3/22 with the ICF/IID program director revealed she was not certain if staff were being told facial masks were mandatory. Review on 5/3/22 of the facility's updated

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

		ENTERO FOR MEDICARE & MEDICAID SERVICES	CIVID NO. USSO-USS I
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

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11:40:57 a.m. 05-12-2022

19/20

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **405 WEST WASHINGTON STREET LAGRANGE HOME** LA GRANGE, NC 28551 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) W 340 Continued From page 13 W 340 COVID-19 policy regarding COVID-19 vaccinations for staff dated 1/24/22 did not include specific information regarding the wearing of personal protective equipment. Review on 5/3/22 of North Carolina Department of Health and Human Services (NCDHHS) policy on Mask Guidance effective date 3/7/22 revealed, "Masks are still required in places like health care and long term care. This is because of the setting or federal regulations."