STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G171	A. BUILDING _____ B. WING _____	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGRANGE HOME	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure personal privacy for 1 of 3 audit clients (#4). The finding is: During morning observations in the home on 5/9/23 at 7:30 am, a sign hung on the wall near the medication cabinet and entrance to the kitchen that was dated 9/27/21. The sign spoke of client #4's Mental Health Guidelines that restricted his use of caffeine. An additional observation at 8:15 am, in the living room, three signs were hung above the table, near the front door that pertained to client #4. The signs had instructions for reminders to prompt client #4 to remove his hat in the home, his cigarette smoking schedule and rules as well identifying that he was an elopement risk. Record review on 5/8/23 of client #4's Individual Program Plan (IPP) dated 7/22/22 revealed he smoked cigarettes and should be monitored 24/7 since elopements had been attempted. Interview on 5/9/23 with the qualified intellectual disabilities professional (QIDP) and the Program Director both acknowledged making prior visits to the home. Both the Program Director and QIDP revealed they never noticed the signs in the home about client #4 and would have them removed to ensure his privacy.	W 129		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii)	W 263		

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

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W 263	Continued From page 1	W 263		

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 record review and interviews, the facility failed to ensure a restrictive Behavior Support Plan (BSP) was conducted with the written consent of both guardians. This affected 1 of 3 audit clients (#4). The finding is:

Review on 5/8/23 of client #4's guardianship status revealed both parents were listed on the court document as co-guardians as of 8/24/20. An additional review of the Individual Program Plan (IPP) Informed Consent, signed by the mother on 2/27/23 revealed she was the only parent who consented to all rights restrictions outlined in the IPP and consented to those restrictions.

Interview on 5/9/23 with the nurse revealed that she has had trouble getting client #4's guardians to consent to dental treatments and it was difficult securing any response. The nurse revealed she has looked into getting the courts involved to revoke it.

Interview on 5/9/23 with the Qualified Intellectual Disabilities Professional (QIDP) and Program Director revealed they were only required to get one signature from the guardians, if the couple was married and lived in the same household, for the BSP consent.

Interview on 5/9/23 with the Compliance Affairs Coordinator (CAC) revealed they do not require both of the guardians signature for informed consent of the BSP. The CAC also revealed in

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W 263	Continued From page 2 previous conversations with the father of client #4 he wanted all documents to go through his wife. The CAC revealed the facility has found the mother to not be very responsive to requests to give consents to treatment.	W 263		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer all medications prescribed by the physician without error. This affected 1 of 3 audit client (#1). The finding is: During morning medication administration observations in the home on 5/9/23 at 7:20 AM, Staff E assisted client #1 with removing a Synthroid 88 mcg pill from a blister pack, to ingest. An additional observation at 7:30 AM revealed client #1 sitting at the dining room table eating breakfast. Review on 5/9/23 of the Physician's Orders for client #1 signed on 12/1/22 revealed Synthroid 88 mcg should be taken 30 minutes before breakfast. Interview on 5/9/23 with the Program Director revealed that the nurse had already intended to do a refresher training with the direct care staff passing medications.	W 369		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 440		

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W 440	Continued From page 3 at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct fire drills, per shift, at least quarterly. The finding is: Review on 5/8/23 of the fire drills completed since May 2022 revealed multiple quarters where a drill was not conducted during one of the three shifts. 1st shift fire drill was missed between May-June, 2022. 3rd shift fire drill was missed between July-September 2022. 1st and 2nd shift fire drills were missed between October-December 2022. 1st shift fire drill was missed between January-March 2023. Interview with the Program Director revealed there was turnover with staff in the home, plus long gaps of vacant house manager position resulting in fire drills missed.	W 440		