PRINTED: 02/08/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		34G053	B. WING			02/07/2024	
NAME OF PROVIDER OR SUPPLIER MYRON PLACE				STREET ADDRESS, CITY, STATE, ZIF 219 MYRON PLACE SALISBURY, NC 28144	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
E 004	CFR(s): 483.475(a) §403.748(a), §416.4 §441.184(a), §460.4 §483.475(a), §484.4 §485.542(a), §486.4 §494.62(a). The [facility] must of Federal, State and preparedness requirements of this preparedness programments of this preparedness programments of the preparedness programment of the preparedness of the preparednes	54(a), §418.113(a), 84(a), §482.15(a), §483.73(a), 102(a), §485.68(a), 625(a), §485.727(a), 360(a), §491.12(a), somply with all applicable local emergency irements. The [facility] must and maintain a comprehensive edness program that meets the section. The emergency ram must include, but not be wing elements: a. The [facility] must develop nergency preparedness plan wed], and updated at least plan must do all of the 482.15 and CAHs at regency Plan. The [hospital or with all applicable Federal, ergency preparedness [hospital or CAH] must ain a comprehensive edness program that meets the section, utilizing an	EO				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		34G053	B. WING		02/07/2024	
NAME OF PROVIDER OR SUPPLIER MYRON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	, 52.	
(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 CORREC ((EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 004	* [For ESRD Facilitic Plan. The ESRD farmaintain an emerge must be [evaluated years.] This STANDARD is Based on record refailed to ensure that Preparedness Plan updated at least even Review of the facility EPP Manual January, 2022. Con EPP manual reveal information for 6 ou #5, #6). Interview with the Preconfirmed that the Brequired since January PROGRAM MONIT CFR(s): 483.440(f). The committee shomonitor individual pinappropriate behaviors.	es at §494.62(a):] Emergency cility must develop and ency preparedness plan that], and updated at least every 2 is not met as evidenced by: eview and interview, the facility it the Emergency (EPP) was reviewed and ery two years. The finding is: ey EPP on 2/6/24 revealed a which was last updated in attinued review of the facility ed outdated client specific it of 6 clients (#1, #2, #3, #4, erogram Manager on 2/7/24 EPP had not been reviewed as lary, 2022. FORING & CHANGE (3)(i) uld review, approve, and rograms designed to manage vior and other programs that, a committee, involve risks to	E 0	04		
	Based on observat interviews, the facili restrictive technique reviewed annually b	s not met as evidenced by: cions, record reviews and ity failed to ensure that es were monitored and by the human rights committee ents (#2 and #4). The findings				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G053	B. WING		02/	07/2024
NAME OF PROVIDER OR SUPPLIER MYRON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
W 262			W 262	2		
	survey period from to put on soft mitter Continued observa	roughout the recertification 2-6-24 - 2-7-24 revealed staff as on both of client #2 hands. tion revealed staff to remove aner and breakfast meals.				
	Review of client #2 record on 2/7/24 revealed a behavior support plan (BSP) dated 6/25/20 with the objective stating the following; By 8/1/22, client #2 will demonstrate nine consecutive months with zero episodes of disruptive behavior associated with habilitation procedures. Continued review of the BSP revealed the following targeted behaviors; restrictive behavior, hand/finger chewing, and refusing to cooperate. Further review revealed client #2 will wear gloves at all times except with eating, bathing, toileting or sleeping. The gloves will be removed during these times. If the client attempts to hand/finger chew when the gloves are off, staff will redirect her and give her hands something to do to stay busy and not chew.					
	medication Ativan p treatments. Additio	of the BSP revealed the prescribed for dental and other nal review did not reveal led, monitored and reviewed C.				
	2/7/24 revealed that not be located during interview with the F	rogram manager (PM) on It signed consent forms could ng the survey. Continued PM verified HRC limitation all clients should be updated HRC annually.				
		oughout the recertification 2-6-24 - 2-7-24 revealed client				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		34G053	B. WING		02/	07/2024	
NAME OF PROVIDER OR SUPPLIER MYRON PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 219 MYRON PLACE SALISBURY, NC 28144	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
W 262	#4's bedroom close door. Review of client #4'BSP dated 1/18/23 behaviors; verbal d property destruction Continued review relocked at all times periodical continuity and toiletry	ge 3 at to require a key to open the as record on 2/7/24 revealed a with the following targeted isruption, physical aggression, a, stripping and stealing. evealed client's closet will be our guardian's request due to a destruction. Further review ents were signed, monitored	W 2	62			
W 263	signed consent forr the survey. Continu verified HRC limitat clients should be up annually.	M on 2/7/24 revealed that ms could not be located during ed interview with the PM ion consent forms for all odated and signed by the HRC TORING & CHANGE	W 2	63			
	are conducted only consent of the clien minor) or legal guar This STANDARD i Based on observat interviews, the facil techniques were re	uld insure that these programs with the written informed it, parents (if the client is a rdian. It is not met as evidenced by: it is, record reviews and ity failed to ensure restrictive viewed and approved by the 2 of 6 clients (#2 and #4). The					
	survey period from to put on soft mitter Continued observa	roughout the recertification 2-6-24 - 2-7-24 revealed staff ns on both of client #2 hands. tion revealed staff to remove ner and breakfast meals.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G053	B. WING			02/	07/2024
NAME OF PROVIDER OR SUPPLIER MYRON PLACE				219	EET ADDRESS, CITY, STATE, ZIP CODE MYRON PLACE LISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 263	Review of client #2 behavior support pl the objective stating client #2 will demore months with zero er associated with hat Continued review or following targeted behand/finger chewing Further review revers at all times except as sleeping. The glove these times. If the or chew when the glove her and give her hat busy and not chew, medication Ativan patreatments. Subsequent review dated 3/4/22. Addition updated signed cor Interview with the patreatments or Interview with the patreatments or continued interview forms for all clients by the legal guardia B. Observations the survey period from #4's bedroom close door. Review of client #4'	record on 2/7/24 revealed a an (BSP) dated 6/25/20 with g the following; By 8/1/22, istrate nine consecutive bisodes of disruptive behavior bilitation procedures. If the BSP revealed the behaviors; restrictive behavior, g, and refusing to cooperate, aled client #2 will wear gloves with eating, bathing, toileting or its will be removed during belient attempts to hand/finger wes are off, staff will redirect ands something to do to stay BSP also revealed the prescribed for dental and other revealed a signed consent onal review did not reveal and its ent by the legal guardian. In rogram manager (PM) on the tupdated signed consent located during the survey. With the PM verified consent should be updated and signed	W 2	63			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G053	B. WING		02	/07/2024
NAME OF PROVIDER OR SUPPLIER MYRON PLACE				STREET ADDRESS, CITY, STATE, ZIP 219 MYRON PLACE SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
W 263	behaviors; verbal d property destruction Continued review re locked at all times p clothing and toiletry did not reveal cons- guardian. Interview with the F signed consent for the survey. Continu- verified consent for	isruption, physical aggression, n, stripping and stealing. evealed client's closet will be per guardian's request due to redestruction. Further review ents signed by the legal of the second not be located during and interview with the PM ms for all clients should be died by the legal guardian.	W 2	63		