STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G053	A. BUILDING _____ B. WING _____	02/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MYRON PLACE	219 MYRON PLACE SALISBURY, NC 28144

(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 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		

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.

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the Emergency Preparedness Plan (EPP) was reviewed and updated at least every two years. The finding is: Review of the facility EPP on 2/6/24 revealed a facility EPP Manual which was last updated in January, 2022. Continued review of the facility EPP manual revealed outdated client specific information for 6 out of 6 clients (#1, #2, #3, #4, #5, #6). Interview with the Program Manager on 2/7/24 confirmed that the EPP had not been reviewed as required since January, 2022.	E 004		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 2 of 6 clients (#2 and #4). The findings are:	W 262		

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W 262	Continued From page 2 A. Observations throughout the recertification survey period from 2-6-24 - 2-7-24 revealed staff to put on soft mittens on both of client #2 hands. Continued observation revealed staff to remove them during the dinner 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. Subsequent review of the BSP revealed the medication Ativan prescribed for dental and other treatments. Additional review did not reveal consents were signed, monitored and reviewed annually by the HRC. Interview with the program manager (PM) on 2/7/24 revealed that signed consent forms could not be located during the survey. Continued interview with the PM verified HRC limitation consent forms for all clients should be updated and signed by the HRC annually. B. Observations throughout the recertification survey period from 2-6-24 - 2-7-24 revealed client	W 262		

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W 262	Continued From page 3 #4's bedroom closet to require a key to open the door. Review of client #4's record on 2/7/24 revealed a BSP dated 1/18/23 with the following targeted behaviors; verbal disruption, physical aggression, property destruction, stripping and stealing. Continued review revealed client's closet will be locked at all times per guardian's request due to clothing and toiletry destruction. Further review did not reveal consents were signed, monitored and reviewed annually by the HRC. Interview with the PM on 2/7/24 revealed that signed consent forms could not be located during the survey. Continued interview with the PM verified HRC limitation consent forms for all clients should be updated and signed by the HRC annually.	W 262		
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 observations, record reviews and interviews, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 2 of 6 clients (#2 and #4). The findings are: A. Observations throughout the recertification survey period from 2-6-24 - 2-7-24 revealed staff to put on soft mittens on both of client #2 hands. Continued observation revealed staff to remove them during the dinner and breakfast meals.	W 263		

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W 263	Continued From page 4 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. BSP also revealed the medication Ativan prescribed for dental and other treatments. Subsequent review revealed a signed consent dated 3/4/22. Additional review did not reveal an updated signed consent by the legal guardian. Interview with the program manager (PM) on 2/7/24 revealed that updated signed consent forms could not be located during the survey. Continued interview with the PM verified consent forms for all clients should be updated and signed by the legal guardian annually. B. Observations throughout the recertification survey period from 2-6-24 - 2-7-24 revealed client #4's bedroom closet to require a key to open the door. Review of client #4's record on 2/7/24 revealed a BSP dated 1/18/23 with the following targeted	W 263		

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W 263	Continued From page 5 behaviors; verbal disruption, physical aggression, property destruction, stripping and stealing. Continued review revealed client's closet will be locked at all times per guardian's request due to clothing and toiletry destruction. Further review did not reveal consents signed by the legal guardian. Interview with the PM on 2/7/24 revealed that signed consent forms could not be located during the survey. Continued interview with the PM verified consent forms for all clients should be updated and signed by the legal guardian annually.	W 263		