		ID HUMAN SERVICES					M APPROVED
		MEDICAID SERVICES					D. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		34G196	B. WING			02/20/2024	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	109 LONON AVENUE		
LAURELW	OOD GROUP HOME			Ν	MARION, NC 28752		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	i	(X5)
PREFIX	· · ·	Y MUST BE PRECEDED BY FULL	PREFI	Х	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	IATE	
					· · · · · · · · · · · · · · · · · · ·		
W 044		2					
W 341	NURSING SERVICES		W :	341			
	CFR(s): 483.460(c)(5	·)(II)					
	-	st include implementing with					
		interdisciplinary team,					
		e and preventive health					
		e, but are not limited to					
		ble diseases and infections,					
	including the instruction	•					
	imethods of infection						
		not met as evidenced by:					
		n, record review, and					
		ailed to teach and promote					
	infection control techr	-					
	•••	d staff for 4 of 4 audited					
	clients (#1, #2, #3 and	d #4). The findings are:					
	A Observation in the	group home on $2/10/24$ at					
		group home on 2/19/24 at ent #1 to wash hands before					
		tinued observation revealed					
		regular plate, two cups,					
		ate guard and shirt protector					
		e dycem mat was already					
	-	vation revealed client #1 to					
		g dinner meal: precut					
		roccoli, rice, punch, and two					
	percent milk.						
	Observation in the	our home or $2/20/24$ at 6.54					
		oup home on 2/20/24 at 6:54					
		to enter the kitchen and					
		e, two cups, silverware,					
		ard to the table with staff					
		d observation revealed client					
		akfast meal of two omelets,					
	-	of whole wheat toast, orange					
	juice and grape juice.						
		carry her dishes to the					
		her plate. At no point during					
	-	was client #1 prompted to					
	wash or use an alcoh	ol-based sanitizer to clean					
	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	F		TITLE		(X6) DATE

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

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.

PRINTED: 02/21/2024 FORM APPROVED

TITLE

	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	: 02/21/2024 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	(X3) DATE SURVEY COMPLETED			
		34G196	B. WING		_	02/2	20/2024
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
LAURELWOOD GROUP HOME				09 LONON AVENUE IARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 341	her hands before com Review of records for revealed a person-cet 3/2/23. Continued rev following goals: impro- self-help skills, improv- make bed, bathe self, dish washer, privacy, behaviors, and increa Interviews with the qu professional (QIDP) a 2/20/24 revealed staff hand hygiene or used sanitizer before all me activity, whenever wo anytime their hands b B. Observation in the 5:10 PM revealed client the dinner meal. Cont client #2 to carry her p napkin, and plate gua her dycem mat had al observation revealed following dinner meal: broccoli, rice, punch, a Observation in the gro 6:35AM revealed client medication administra revealed client #2 to r medication basket fro observation revealed description of her med pop her medication in observation revealed	suming the breakfast meal. client #1 on 2/20/24 htered plan (PCP) dated iew of the PCP revealed the ve daily living skills, improve // eating skills/manners, wipe after toileting, load decrease maladaptive se communication. alified intellectual disabilities ind home manager (HM) on and clients should perform an alcohol-based hand eals, after any self-care rking with clients and ecome soiled. group home on 2/19/24 at int #2 to wash hands before inued observation revealed olate, cups, silverware, rd to the dinner table where ready been placed. Further client #2 consume the precut teriyaki pork chops, and two percent milk. oup home on 2/20/24 at ht #2 to participate in ation. Continued observation eceive a prompt to retrieve m the cabinet. Further Client #2 to receive a dication and assistance to to a medicine cup. Further	W 341		DEFICIENCY)		

Facility ID: 922109

If continuation sheet Page 2 of 6

	MENT OF HEALTH AN					FORM	: 02/21/2024 APPROVED
STATEMENT	S FOR MEDICARE & I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED			
		34G196	B. WING		_	02/2	20/2024
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
LAURELV	OOD GROUP HOME			09 LONON AVENUE IARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 341	Subsequent observati hurriedly throw the me and walk out of the m pill remaining in the co from the garbage. At m medication pass did S sanitize their hands. Observation in the me 6:40 AM revealed Stat trash can to retrieve th in the medication cup revealed Staff D to lay exit the room to repor manager. Further observati prompt another client Review of records for revealed a PCP dated of the PCP revealed t daily living skills, increas decrease maladaptive awareness, improve t eating skills/manners, activity. Interviews with the QI revealed staff and clies hygiene or used an al before all meals, after whenever working with hands become soiled.	on revealed client #2 to edication cup in the trashcan edication room leaving one up that Staff D retrieved no point before or during the staff D or client #2 wash or edication room on 2/20/24 at ff D to dig throughout the ne pill client #2 threw away . Continued observation v the pill on the desk and t the event to the home ervation revealed Staff D to she needed to notify dose/dropped pill. on revealed Staff D to for medication pass. client #2 on 2/20/24 I 6/21/23. Continued review the following goals: improve ease independent living ng, make med, improve se communication skills, e behaviors, community oothbrushing, improve and attend to one leisure DP and HM on 2/20/24 ents should perform hand cohol-based hand sanitizer any self-care activity, h clients and anytime their	W 341				

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						O. 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SUR COMPLETE	
		34G196	B. WING		02	2/20/2024
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAURELV	VOOD GROUP HOME			109 LONON AVENUE MARION, NC 28752		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
W 341	COOD GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 6:45 AM revealed Staff D to prompt client #4 to come inside the medication room for his medication pass. Continued observation revealed Staff D to retrieve a spoon, medication cup and small container of apple sauce to place on the desk for client #4's medication pass. Further observation revealed Staff D to lay the spoon on a yellow sticky notepad present on the desk. Subsequent observation revealed Staff D to begin client #4's medication administration. Observation in the group home on 2/20/24 at 6:45 AM revealed Staff D to retrieve client #4 medication basket from the closet. Continued observation revealed Client #4 to receive a description of his medication, assist Staff D with popping his medication into her hand from the bubble pack. Further observation revealed Staff D to retrieve the spoon from the yellow sticky note pad, open the apple sauce container, load the pill cup, stir, and feed client #4 his medications. At no point before or during the medication administration did Staff D or client #4 wash or sanitize their hands. Additionally, Staff D failed to ensure that the surface of the desk was sanitized before placing Client #4's spoon on the surface. Observation in the group home on 2/20/24 at 6:53 AM revealed client #4 to the leave the medication room and enter the dining room for his breakfast meal. Continued observation revealed client #4 to get his deep-dish bowl, silverware, and two sip cups to place on the table with staff assistance. Further observation revealed client #4 to		W 34			

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	-				FO	ED: 02/21/2024 RM APPROVED			
STATEMENT OF DEFICIENCIES (X1) PI		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	(X3) DA	NO. 0938-0391 TE SURVEY MPLETED				
		34G196	B. WING		C	2/20/2024			
NAME OF PR	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP					
			109	109 LONON AVENUE					
LAURELWOOD GROUP HOME			МА	RION, NC 28752					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE			
W 341	Continued From page	2 4	W 341						
	the breakfast meal wash or use an alcoh	e juice. At no point before as client #4 prompted to ol-based sanitizer to clean suming the breakfast meal.							
	of the PCP revealed t self, pick up bedroom improve eating skills/r skills - toothbrushing,	client #4 on 2/20/24 d 7/28/23. Continued review he following goals: bathe , follow toileting schedule, manners, increase self-help improve daily living-skills, e behaviors, and increase							
	revealed staff and clie hygiene or used an al before all meals, after	DP and HM on 2/20/24 ents should perform hand cohol-based hand sanitizer any self-care activity, ch clients and anytime their							
	5:13 PM revealed clie the dinner meal. Cont client #3 to carry his r silverware, and napkin observation revealed following dinner meal: broccoli, rice, punch,	client #3 to consume the : precut teriyaki pork chops,							
	AM revealed client #3 carry regular plate, tw table. Continued obse consume a breakfast pieces of whole whea grape juice. Further o #3 carried his dishes	to enter the kitchen and to cups and silverware to the ervation revealed client #3 to meal of two omelets, two t toast, orange juice and bservation revealed client to the kitchen, rinsed them the dishwasher. At no point							

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		34G196	B. WING			02/	20/2024	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
LAURELV	OOD GROUP HOME				109 LONON AVENUE MARION, NC 28752			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
W 341	to wash or use an alc clean his hands befor meal. Review of records for revealed a PCP dated of the PCP revealed t self, attend to one leis improve eating skills/i face, use spoon durin toileting, reduce mala communication progri Interviews with the Q revealed staff and clie hygiene or used an a before all meals, after	meal was client #3 prompted ohol-based sanitizer to re consuming the breakfast client #3 on 2/20/24 d 3/2/23. Continued review the following goals: bathe sure item, load dishwasher, manners, privacy, shave ng mealtime, wipe after daptive behavior, and am. IDP and HM on 2/20/24 ents should perform hand lcohol-based hand sanitizer r any self-care activity, th clients and anytime their	W	341				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 922109

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