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	34G051	A. BUILDING _____ B. WING _____	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURA SPRINGS ROAD HOME	309 LAURA SPRINGS DR SALISBURY, NC 28144

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W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that privacy was maintained for 1 of 5 audit clients (#5). The finding is: During observations in the home on 6/4/24 at 4:52 PM, client #5 was observed to walk from the living room to the bathroom. Staff B was observed to follow client #5. Further observations revealed client #5 to pull his pants down and sit down on the toilet, with Staff B standing in the bathroom doorway with the door fully opened. At 4:55PM, client #5 finished in the bathroom. The door remained opened the duration client #5 was in the bathroom, without Staff B closing the door or prompting client #5 to close the door. Review on 6/4/24 of client #5's person centered plan (PCP) dated 10/18/23 revealed client #5 requires prompts to close the bathroom door for privacy. Interview on 6/5/24 with the program manager (PM) confirmed when client #5 is in the bathroom, staff should prompt him to close the door or close the door for him to maintain his privacy.	W 130		
W 250	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.	W 250		

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

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W 250	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, facility failed to ensure the person-centered plan (PCP) for 2 of 5 audit clients (#4 and #6) was available for review. The findings are: A. Review on 6/4/24 of client #4's record revealed a PCP dated 12/12/22. Further review on 6/5/24 of records available in the home revealed a PCP dated 12/12/22. Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) revealed the PCP located in the records was the PCP available to staff. The QIDP revealed the most current PCP, unsigned, was available at the office. B. Review on 6/4/24 of client #6's record revealed a PCP dated 12/19/22. Further review on 6/5/24 of records available in the home revealed a PCP dated 12/19/22. Interview on 6/5/24 with the QIDP revealed the PCP located in the records was the PCP available to staff. The QIDP revealed the most current PCP, unsigned, was available at the office.	W 250		
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:	W 262		

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W 262	Continued From page 2 Based on record review and interview, the facility failed to ensure the behavior support plan (BSP) for 1 of 5 audit clients (#4) was reviewed and monitored by the human rights committee (HRC). The finding is: Review on 6/4/24 of client #4's record revealed a behavior support plan (BSP) dated 3/13/20, which included a rights limitation by locking his closet door to restrict access to his clothing. Further review of the record revealed the last consent by the HRC was signed on 2/20/23. Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) confirmed the last consent that could be located during the survey was dated 2/20/23.	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 record review and interview, the facility failed to ensure restrictive programs were only conducted with the written informed consent of a legal guardian. This affected 1 of 5 audit clients (#4). The finding is: Review on 6/4/24 of client #4's record revealed a behavior support plan (BSP) dated 3/13/20, which included a rights limitation by locking his closet door to restrict access to his clothing. Further review of the record revealed the last consent by the legal guardian was signed on 2/20/23.	W 263		

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W 263	Continued From page 3 Interview on 6/5/24 with the qualified intellectual disabilities professional (QIDP) confirmed the last consent that could be located during the survey was dated 2/20/23.	W 263		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to assure that adaptive equipment was furnished as prescribed for 2 of 3 sampled clients (#3, #4). The findings are: A. The facility failed to utilize a gait belt to assist client #3 during transfers. For example: Observations during the recertification survey from 6/4/24-6/5/24 revealed client #3 to participate in various activities with staff and peers. Afternoon observations on 6/4/24 at 5:28PM revealed staff to transfer client #3 from the sofa to the wheelchair without utilizing a gait belt. Morning observations on 6/5/24 at 7:10AM revealed two staff to assist client #3 to transfer from the sofa to his wheelchair by holding him underneath his arms. Continued observations revealed staff to transfer client #3 without the use of a gait belt. At no point during the observation period did staff utilize a gait belt to assist with transfers as prescribed. Review of the record for client #3 on 6/5/24	W 436		

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revealed a person centered plan (PCP) dated 9/27/23 and an occupational therapy assessment (OT) assessment dated 5/25/23. Continued review of the PCP and OT assessment indicated client #3 has the following adaptive equipment: gait belt/vest, helmet during seizure activity, high sided dish, sippy cup, shirt protector, built up utensils, noise monitor, knee immobilizers, shower chair, manual lift, wheelchair, bed rails with cushions, and dycem mat.

Interview with the qualified intellectual disabilities professional (QIDP) and program manager (PM) on 6/5/24 revealed staff should have utilized client #3's gait belt during waking hours and transfers. Continued interview with the PM and QIDP verified that client #3's prescribed adaptive equipment is current. Further interview with the PM revealed staff have been trained to utilize client #3's gait belt as prescribed.

B. The facility failed to ensure that client #3's noise monitor is utilized while in his room. For example:

Observations during the 6/4/24-6/5/24 recertification survey did not reveal client #3 to have a noise monitor in his room to be used for frequent seizure activity.

Review of the record for client #3 on 6/5/24 revealed an OT assessment dated 5/25/23 which indicated that client #3 should have the following adaptive equipment to assist with seizure activity: helmet during seizure activity, noise monitor, and bed rails with cushions. Review of the record for client #3 did not reveal that use of the noise monitor had been discontinued.

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Interview with staff C on 6/5/24 revealed she has not seen client #3's noise monitor in his room for at least two years. Interview with the PM on 6/5/24 revealed that client #3 should have a noise monitor in his room due to frequent seizure activity. Further interview with the PM revealed that the adaptive equipment for client #3 is current and staff have been trained to use the noise monitor in the client's room due to seizure activity.

C. The facility failed to provide adequate adaptive equipment for client #4 during mealtimes. For example:

Observations during the 6/4/24-6/5/24 recertification survey revealed client to participate in mealtimes using the following adaptive equipment: green plastic tablespoon and high sided divided dish. Observations did not reveal staff to provide client #4 with a small maroon spoon during mealtimes.

Review of the record for client #4 revealed a PCP dated 2/22/24 and an OT assessment dated 11/27/22. Continued review of the PCP and OT assessment indicated that client #4 should have the following adaptive equipment: small maroon spoon or other small-bowled spoon, high sided dish and catheter bag. Further review of the record for client #4 did not indicate adaptive equipment had been discontinued.

Interview with the QIDP on 6/5/24 revealed that she has seen client #4 utilize a maroon spoon during mealtimes. Continued interview with the QIDP revealed that she is not sure how client #4 received access to the plastic green tablespoon during mealtimes. Further interview with the

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W 436	Continued From page 6 QIDP verified that all of client #4's adaptive equipment is current. Additional interview with the QIDP revealed staff should provide the appropriate adaptive equipment for client #4 during mealtimes due to his history of choking.	W 436		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) 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 ensure fire drills were conducted at least quarterly for each shift. The finding is: Review on 6/4/24 of the facility's fire drills conducted May 2023 through May 2024 revealed the following drills were missing: September 2023, October 2023, November 2023, December 2023, February 2024 and April 2024. Interview on 6/5/24 with the program manager (PM) confirmed fire drills should be completed monthly.	W 440		
W 474	MEAL SERVICES CFR(s): 483.480(b)(2)(iii) Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure food was served in a form consistent with the developmental level for 4 of 5 audit clients (#2, #3, #4 and #6). The findings are: A. During observations in the home on 6/5/24 at 7:15AM, client #2 was observed eating breakfast which consisted of cheese grits, three sausage	W 474		

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links and a bowl of peaches. The three sausage links were served in whole form, with client #2 eating all three pieces.

Review on 6/4/24 of client #2's person-centered plan (PCP), undated, revealed a diet order consisting of 1/4" pieces.

Interview on 6/5/24 with the program manager (PM) confirmed client #2's sausage should have been served in 1/4" pieces.

B. During observations in the home on 6/5/24 at 7:15AM, client #4 was observed eating breakfast which consisted of cheese grits, three sausage links and a bowl of peaches. The cheese grits and sausage links were served in a ground consistency.

Review on 6/5/24 of client #4's PCP dated 12/12/22 revealed a diet order consisting of a pureed consistency.

Interview on 6/5/24 with the PM confirmed client #4's food should have been served in a pureed consistency.

C. During observations in the home on 6/5/24 at 7:15AM, client #6 was observed eating breakfast which consisted of cheese grits and three sausage links. The three sausage links were served in whole form, with client #6 eating all three pieces.

Review on 6/4/24 of client #6's PCP dated 12/19/22 revealed a diet order consisting of 1/4" pieces and ground meats.

Interview on 6/5/24 with the PM confirmed client

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W 474	Continued From page 8 #6's sausage should have been served in a ground consistency. D. The facility failed to assure food consistency was provided to client #3 as prescribed. For example: Morning observations on 6/5/24 at 7:15AM revealed staff to transition client #3 to the dining room to prepare for the breakfast meal. The breakfast meal consisted of cheese grits, 2 turkey sausage links, sliced peaches, milk, and water. Continued observation revealed staff to cut client #3's turkey sausage links into bite size pieces. Further observation revealed staff to feed client #3 the turkey sausage and cheese grits. At no point during the observation did staff prepare client #3's turkey sausage into a ground consistency. Review of the record for client #3 on 6/5/24 revealed a PCP dated 9/27/23 and an annual nutritional assessment dated 2/20/24 which indicated that client #3 should be served food in a ¼" consistency with ground meats. Continued review of the annual nutritional assessment revealed that client #3 should also be on a weight gain diet with thin liquids, high calorie drinks, Boost 3 times a day, and whole milk with breakfast and dinner. Interview with the program manager (PM) on 6/5/24 revealed staff have been trained to prepare and serve client #3's meats in a ground consistency. Continued interview with the PM verified client #3's prescribed diet is current. Further interview with the PM revealed staff should follow the clients' prescribed diets during mealtimes.	W 474		

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