DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		34G051	B. WING			06/	05/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	PRINGS ROAD HOM	F		3	09 LAURA SPRINGS DR		
		E		S	SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPN DEFICIENCY)	BE	(X5) COMPLETION DATE
W 130	PROTECTION OF CFR(s): 483.420(a)		W 1	130			
W 250	Therefore, the facilit treatment and care This STANDARD is Based on observati interview, the facilit was maintained for finding is: During observations 4:52 PM, client #5 M living room to the b observed to follow of revealed client #5 to down on the toilet, w bathroom doorway 4:55PM, client #5 fi door remained oper in the bathroom, wi or prompting client Review on 6/4/24 of plan (PCP) dated 1 requires prompts to privacy. Interview on 6/5/24 (PM) confirmed why staff should prompt	s not met as evidenced by: tion, record review and y failed to ensure that privacy 1 of 5 audit clients (#5). The s in the home on 6/4/24 at was observed to walk from the athroom. Staff B was client #5. Further observations o pull his pants down and sit with Staff B standing in the with the door fully opened. At nished in the bathroom. The ned the duration client #5 was thout Staff B closing the door #5 to close the door. f client #5's person centered 0/18/23 revealed client #5 o close the bathroom door for with the program manager en client #5 is in the bathroom, him to close the door or close maintain his privacy.	W 2				
	CFR(s): 483.440(d) The facility must de schedule that outlin	-					
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		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.

PRINTED: 06/05/2024

					FORM	06/05/2024 APPROVED 0938-0391
OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
	34G051	B. WING			06/	05/2024
ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
PRINGS ROAD HOM	E					
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE
This STANDARD is Based on record refailed to ensure the for 2 of 5 audit clien for review. The find A. Review on 6/4/24 a PCP dated 12/12/ Further review on 6 the home revealed Interview on 6/5/24 disabilities profession located in the recor- staff. The QIDP re- unsigned, was avail B. Review on 6/4/24 a PCP dated 12/19/ Further review on 6 the home revealed Interview on 6/5/24 PCP dated 12/19/ Further review on 6 the home revealed Interview on 6/5/24 PCP located in the available to staff. T	s not met as evidenced by: eview and interview, facility person-centered plan (PCP) nts (#4 and #6) was available dings are: 4 of client #4's record revealed /22. 5/5/24 of records available in a PCP dated 12/12/22. with the qualified intellectual onal (QIDP) revealed the PCP ds was the PCP available to vealed the most current PCP, lable at the office. 4 of client #6's record revealed /22. 5/5/24 of records available in a PCP dated 12/19/22. with the QIDP revealed the records was the PCP 'he QIDP revealed the most	W 2	250			
PROGRAM MONIT CFR(s): 483.440(f) The committee sho monitor individual p inappropriate behav in the opinion of the client protection and	(3)(i) ould review, approve, and programs designed to manage vior and other programs that, a committee, involve risks to d rights.	W 2	262			
	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION PROVIDER OR SUPPLIER SPRINGS ROAD HOM SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa This STANDARD is Based on record ref failed to ensure the for 2 of 5 audit client for review. The find A. Review on 6/4/24 a PCP dated 12/12/ Further review on 6 the home revealed Interview on 6/5/24 disabilities profession located in the record staff. The QIDP revious avail B. Review on 6/4/24 a PCP dated 12/19/ Further review on 6 the home revealed Interview on 6/5/24 disabilities profession located in the record staff. The QIDP revious avail B. Review on 6/4/24 a PCP dated 12/19/ Further review on 6 the home revealed Interview on 6/5/24 PCP located in the available to staff. The current PCP, unsign office. PROGRAM MONIT CFR(s): 483.440(f)(The committee sho monitor individual p inappropriate behavion in the opinion of the client protection and	IDENTIFICATION NUMBER: 34G051 PROVIDER OR SUPPLIER SPRINGS ROAD HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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 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. B. Review on 6/5/24 of records available in the home 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.	RS FOR MEDICARE & MEDICAID SERVICES IOF DEFICIENCIES FORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 34G051 B. WING PROVIDER OR SUPPLIER 34G051 B. WING SPRINGS ROAD HOME ID B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 1 W 2 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: W 2 A. Review on 6/4/24 of client #4's record revealed a PCP dated 12/12/22. W 1 Further review 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 6/5/24 vith the QIDP revealed the 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 2 PROGRAM MONITORING & CHANGE in the opinion of the committee, involve risks to client protection and rights. W 2	RS FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL NF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL 34G051 B. WING	IMENT OF HEALTH AND HUMAN SERVICES Of SFOR MEDICARE & MEDICAID SERVICES Of OF DEFICIENCIES (X1) PROVIDER/SUPPLIENCUA DENTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A BUILDING PROVIDER OR SUPPLIER 34G051 B. WING SPRINGS ROAD HOME STREET ADDRESS, CITY, STATE, ZIP CODE 399 LAURA SPRINGS DR SALISBURY, NC 28144 SUMMARY STATEMENT OF DEFICIENCIES (EACH DERFORMENT OF DEFICIENCIES) ID PROVIDERS PLAN OF CORRECTION (EACH DERFORMENT AND THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION (EACH DERFORMENT AND THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION (EACH DERFORMENT AND THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH ORRECTING AND AND IS NOT THE APPROPH DEFICIENCY) Continued From page 1 W 250 W 250 This STANDARD is not met as evidenced by: Based on record review and interview, facility raide to ensure the person-centered plan (PCP) for 2 of 5 audit clients (#4 and #6) was available for review on 61/24 of client #4's record revealed a PCP dated 12/12/22. W 250 Further review on 61/5/24 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. W 262 PROGRAM MONITORING & CHANGE (FR(s): 483.440(f)(3)(i) W 262	MENT OF HEALTH AND HUMAN SERVICES FORM. SF OR MEDICARE & MEDICAID SERVICES OMB NO. OF OFFICIENCIES (X1) PROVIDER/SUPPLEXICUA (X2) MULTIPLE CONSTRUCTION (X3) DATA PROVIDER OR SUPPLER 34G051 B. WING 06// PROVIDER OR SUPPLER STREET ADDRESS. CITY, STATE, ZP CODE 39 LAURA SPRINGS DR SALISBURY, IC 28144 SALISBURY, IC 28144 06// Continued From page 1 W 250 CACH CORRECTION MIST BE PRECEDED BY FULL FORWIDER SPLANOF CORRECTION ECORPORTATE 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: W 250 EACH CORRECTION (DDP) A. Review on 6//224 of crecords available in the home 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. Further review on 6//5/24 of records available in the home revealed a PCP dated 12/19/22. Further review on 6//24 with the QUBIP 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 262 PROCREM MONITORING & CHANGE W 262 CFR(s): 483.440(f)(3)(i) W 262 There committee should review, approve, and monitor individual programs designed to manage inaproprinate behavior and other programs

If continuation sheet Page 2 of 10

		AND HUMAN SERVICES				FORM	06/05/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G051	B. WING			06/	05/2024
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	:	
LAURA S	PRINGS ROAD HOM	E			09 LAURA SPRINGS DR ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
W 262	Based on record refailed to ensure the for 1 of 5 audit client monitored by the hull The finding is: Review on 6/4/24 o behavior support plincluded a rights lim door to restrict accertive of the record the HRC was signed Interview on 6/5/24 disabilities profession consent that could I was dated 2/20/23. PROGRAM MONIT CFR(s): 483.440(f) The committee sho are conducted only consent of the client minor) or legal guard This STANDARD is Based on record refailed to ensure ress conducted with the legal guardian. Thi (#4). The finding is Review on 6/4/24 o behavior support plincluded a rights lim door to restrict accertive of the record refailed to ensure ress conducted with the legal guardian. Thi (#4). The finding is Review on 6/4/24 o behavior support plincluded a rights lim door to restrict accertive of the record review of the record review of the record refailed to ensure ress conducted with the legal guardian. Thi (#4). The finding is Review on 6/4/24 o behavior support plincluded a rights lim door to restrict accertive of the record refailed to the record refailed to ensure ress conducted with the legal guardian. Thi (#4). The finding is Review on 6/4/24 o behavior support plincluded a rights lim door to restrict accertive of the record refailed to the record refailed to the record refailed to the record refailed to ensure ress conducted with the legal guardian. Thi (#4). The finding is Review on 6/4/24 o behavior support plincluded a rights lim door to restrict accertive review of the record refailed to the record	eview and interview, the facility e behavior support plan (BSP) ints (#4) was reviewed and uman rights committee (HRC). If client #4's record revealed a lan (BSP) dated 3/13/20, which initation by locking his closet ess to his clothing. Further d revealed the last consent by ed on 2/20/23. with the qualified intellectual onal (QIDP) confirmed the last be located during the survey FORING & CHANGE (3)(ii) build insure that these programs with the written informed nt, parents (if the client is a rdian. s not met as evidenced by: eview and interview, the facility strictive programs were only written informed consent of a is affected 1 of 5 audit clients	W 2				

If continuation sheet Page 3 of 10

		AND HUMAN SERVICES				FORM	06/05/2024 APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DATE	0938-0391 E SURVEY PLETED
		34G051	B. WING			06/0	05/2024
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAURAS	SPRINGS ROAD HOM	E			09 LAURA SPRINGS DR SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 263 W 436	Interview on 6/5/24 disabilities profession consent that could lives dated 2/20/23.	with the qualified intellectual onal (QIDP) confirmed the last be located during the survey	W 2 W 2				
W 430	CFR(s): 483.470(g) The facility must fur and teach clients to choices about the u hearing and other of and other devices is interdisciplinary tea This STANDARD is Based on observat interview, the facility equipment was furr sampled clients (#3 A. The facility failed client #3 during tran Observations during from 6/4/24-6/5/24 participate in variou peers. Afternoon o 5:28PM revealed st the sofa to the whe belt. Morning obse revealed two staff to from the sofa to his underneath his arm revealed staff to tra of a gait belt. At no period did staff utiliz transfers as prescri	(2) rnish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces, dentified by the m as needed by the client. s not met as evidenced by: tions, record review and y failed to assure that adaptive hished as prescribed for 2 of 3 8, #4). The findings are: It to utilize a gait belt to assist hisfers. For example: g the recertification survey revealed client #3 to us activities with staff and bservations on 6/4/24 at taff to transfer client #3 from elchair without utilizing a gait rvations on 6/5/24 at 7:10AM o assist client #3 to transfer wheelchair by holding him us. Continued observations insfer client #3 without the use point during the observation ze a gait belt to assist with					

If continuation sheet Page 4 of 10

		AND HUMAN SERVICES				FORM	06/05/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G051	B. WING			06/	05/2024
NAME OF F	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAURA	SPRINGS ROAD HOM	E			09 LAURA SPRINGS DR ALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 436	revealed a person of 9/27/23 and an occ (OT) assessment d review of the PCP a client #3 has the fol gait belt/vest, helme sided dish, sippy cu utensils, noise mon shower chair, manu with cushions, and Interview with the q professional (QIDP on 6/5/24 revealed #3's gait belt during Continued interview verified that client # equipment is curren PM revealed staff h client #3's gait belt B. The facility failed noise monitor is util example: Observations during recertification surve have a noise monito frequent seizure ac Review of the recor revealed an OT ass indicated that client adaptive equipment helmet during seizu bed rails with cushi	centered plan (PCP) dated supational therapy assessment lated 5/25/23. Continued and OT assessment indicated llowing adaptive equipment: et during seizure activity, high up, shirt protector, built up nitor, knee immobilizers, ual lift, wheelchair, bed rails dycem mat. ualified intellectual disabilities) and program manager (PM) staff should have utilized client g waking hours and transfers. with the PM and QIDP f3's prescribed adaptive nt. Further interview with the nave been trained to utilize as prescribed. It to ensure that client #3's lized while in his room. For g the 6/4/24-6/5/24 ey did not reveal client #3 to or in his room to be used for tivity. rd for client #3 on 6/5/24 sessment dated 5/25/23 which a #3 should have the following t to assist with seizure activity: ure activity, noise monitor, and ons. Review of the record for yeal that use of the noise	W 4	436			

If continuation sheet Page 5 of 10

		AND HUMAN SERVICES				FORM	06/05/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			(X3) DAT	E SURVEY PLETED
		34G051	B. WING	i		06/	05/2024
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAURA	SPRINGS ROAD HOM	E			309 LAURA SPRINGS DR SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
W 436	Interview with staff not seen client #3's at least two years. I 6/5/24 revealed that monitor in his room activity. Further inter that the adaptive ec- current and staff hat noise monitor in the activity. C. The facility failed equipment for client example: Observations during recertification surver in mealtimes using equipment: green sided divided dish. staff to provide client spoon during mealt Review of the record dated 2/22/24 and a 11/27/22. Continue assessment indicat the following adaptit spoon or other smat dish and catheter b record for client #4 equipment had bee Interview with the C she has seen client during mealtimes. C QIDP revealed that received access to	C on 6/5/24 revealed she has noise monitor in his room for Interview with the PM on it client #3 should have a noise due to frequent seizure erview with the PM revealed quipment for client #3 is ave been trained to use the e client's room due to seizure d to provide adequate adaptive t #4 during mealtimes. For g the 6/4/24-6/5/24 ey revealed client to participate the following adaptive plastic tablespoon and high Observations did not reveal int #4 with a small maroon times. rd for client #4 revealed a PCP an OT assessment dated ed review of the PCP and OT ted that client #4 should have ive equipment: small maroon all-bowled spoon, high sided ag. Further review of the did not indicate adaptive	W 2	436			

Facility ID: 922107

If continuation sheet Page 6 of 10

	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	` '	MPLETED
		34G051	B. WING		06	/05/2024
NAME OF I	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
LAURAS	SPRINGS ROAD HOM	1E		309 LAURA SPRINGS DR SALISBURY, NC 28144		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
W 436	- ·	age 6 all of client #4's adaptive	W 436	5		
W 440	the QIDP revealed appropriate adaptiv during mealtimes of		W 44()		
	This STANDARD Based on record r failed to ensure fire	or each shift of personnel. is not met as evidenced by: eview and interview, the facility e drills were conducted at least shift. The finding is:				
	conducted May 20 the following drills	of the facility's fire drills 23 through May 2024 revealed were missing: September 3, November 2023, December 24 and April 2024.				
W 474	Interview on 6/5/24 (PM) confirmed fire monthly. MEAL SERVICES CFR(s): 483.480(b	with the program manager e drills should be completed)(2)(iii)	W 474	1		
	developmental leve This STANDARD Based on observa interviews, the faci served in a form co	is not met as evidenced by: tions, record reviews, and lity failed to ensure food was onsistent with the el for 4 of 5 audit clients (#2,				
	7:15AM, client #2 v	ions in the home on 6/5/24 at was observed eating breakfast cheese grits, three sausage				

		AND HUMAN SERVICES				FORM	06/05/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATI	E SURVEY PLETED
		34G051	B. WING _			06/	05/2024
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LAURAS	SPRINGS ROAD HOM	E			9 LAURA SPRINGS DR ALISBURY, 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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 474	links and a bowl of links were served in eating all three piece Review on 6/4/24 o plan (PCP), undate consisting of 1/4" pi Interview on 6/5/24 (PM) confirmed clie been served in 1/4" B. During observati 7:15AM, client #4 w which consisted of links and a bowl of and sausage links v consistency. Review on 6/5/24 o 12/12/22 revealed a pureed consistency Interview on 6/5/24 #4's food should ha consistency. C. During observati 7:15AM, client #6 w which consisted of sausage links. The served in whole for three pieces. Review on 6/4/24 o 12/19/22 revealed a pieces and ground	peaches. The three sausage n whole form, with client #2 ces. f client #2's person-centered d, revealed a diet order ieces. with the program manager ent #2's sausage should have ' pieces. tons in the home on 6/5/24 at vas observed eating breakfast cheese grits, three sausage peaches. The cheese grits were served in a ground f client #4's PCP dated a diet order consisting of a v. with the PM confirmed client ave been served in a pureed tons in the home on 6/5/24 at vas observed eating breakfast cheese grits and three e three sausage links were m, with client #6 eating all f client #6's PCP dated a diet order consisting of 1/4"	W 47	74			

If continuation sheet Page 8 of 10

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	06/05/2024 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DAT	E SURVEY PLETED
		34G051	B. WING			06/	05/2024
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LAURA S	PRINGS ROAD HOM	E			809 LAURA SPRINGS DR SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 474	 #6's sausage shoul ground consistency D. The facility failed was provided to clie example: Morning observation revealed staff to transform to prepare for breakfast meal consistency and the prepare for breakfast meal consistency. Review of the recorrevealed a PCP date nutritional assessmindicated that client 1/4" consistency with review of the annuar revealed that client gain diet with thin lie Boost 3 times a day breakfast and dinner linterview with the p 6/5/24 revealed staft prepare and serve of consistency. 	d have been served in a d have been served in a d to assure food consistency ent #3 as prescribed. For ns on 6/5/24 at 7:15AM nsition client #3 to the dining the breakfast meal. The sisted of cheese grits, 2 turkey d peaches, milk, and water. tion revealed staff to cut client e links into bite size pieces. a revealed staff to feed client age and cheese grits. At no servation did staff prepare ausage into a ground d for client #3 on 6/5/24 ted 9/27/23 and an annual ent dated 2/20/24 which #3 should be served food in a a ground meats. Continued al nutritional assessment #3 should also be on a weight quids, high calorie drinks, y, and whole milk with	W 2	174			
		ith the PM revealed staff ients' prescribed diets during					

If continuation sheet Page 9 of 10

		AND HUMAN SERVICES			FORM	: 06/05/2024 APPROVED . 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY IPLETED
		34G051	B. WING		06/	/05/2024
NAME OF	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE,	ZIP CODE	
LAURAS	SPRINGS ROAD HOM	E		309 LAURA SPRINGS DR SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE

Facility ID: 922107