STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G171	A. BUILDING _____ B. WING _____	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAGRANGE HOME	405 WEST WASHINGTON STREET LA GRANGE, NC 28551

(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
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure data relative to medication effectiveness was documented. This affected 1 of 3 audit clients (#1 and #3). The findings are: A. Record review on 5/6/25 of client #1's physician's orders signed 12/5/24 revealed client #1 is prescribed Trazadone 100mg, take 1 tablet by mouth at bedtime for sleep. Further record review on 5/6/25 revealed no sleep data had been collected to determine the Trazadone's effectiveness. B. Record review on 5/6/25 of client #3's physician's orders signed 12/5/24 revealed client #3 is prescribed Trazadone 100mg, take 1 tablet by mouth at bedtime. Further record review on 5/6/25 revealed no sleep data had been collected to determine the Trazadone's effectiveness. Interview on 5/6/25 with the facility nurse the facilty does not keep sleep data for client #1 or client #3. The nurse confirmed data would be necessary to determine the medications effectiveness.	W 252		
W 262	PROGRAM MONITORING & CHANGE	W 262		

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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W 262	Continued From page 1 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 record review and interview, the facility failed to ensure the restrictive behavior techniques for 2 of 3 audit clients (#3 and #4) was reviewed and monitored by the human rights committee (HRC). The findings are: A. Review on 5/5/25 of client #3's Individual Program Plan (IPP) revealed an addendum dated 11/14/24 that stated, the food in the home would be locked up due to other residents in the home hoarding food. Further review on 5/5/25 of client #3's plan revealed no review or consent by the HRC. B. Review on 5/5/25 of client #4's Individual Program Plan (IPP) revealed an addendum dated 11/14/24 that stated, the food in the home would be locked up due to other residents in the home hoarding food. Further review on 5/5/25 of client #4's plan revealed no review or consent by the HRC. Interview on 5/6/25 with the interim program director confirmed client #3 and client #4's did not have HRC consent for the locked food.	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	W 263		

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W 263	Continued From page 2 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 2 of 3 audit clients (#3 and #4). The findings are: A. Review on 5/5/25 of client #3's Individual Program Plan (IPP) revealed an addendum dated 11/14/24 that stated, the food in the home would be locked up due to other residents in the home hoarding food. Further review on 5/5/25 of client #3's plan revealed no guardian consent had been obtained. B. Review on 5/5/25 of client #4's Individual Program Plan (IPP) revealed an addendum dated 11/14/24 that stated, the food in the home would be locked up due to other residents in the home hoarding food. Further review on 5/5/25 of client #4's plan revealed no guardian consent had been obtained. Interview on 5/6/25 with the interim program director confirmed client #3 and client #4's did not have guardian consent for the locked food.	W 263		