DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

Image: Construction Description 34G051 B. WING 34G051 B. WING CARA SPRINGS ROAD HOME STREET ADDRESS, CITY, STATE, Zim CODE 04/10 SUMMARY STREEMENT OF DEFICIENCIES PAC REGULTARS SPRINGS ROAD HOME 04/10 SUMMARY STREEMENT OF DEFICIENCIES 04/10 SUMMARY STREEMENT OF DEFICIENCIES PAC PROVIDER'S PLAN OF CORRECTION ACTION SHOLD BE 04/10 SUMMARY STREEMENT OF DEFICIENCIES 05/10/2025 PROVIDER'S PLAN OF CORRECTION ACTION SHOLD BE 05/10 CECKCOMERCETINA ACTION SHOLD BE 06/10 CECKCOMERCETINA ACTION SHOLD BE 07/10 SHOLLANG SPRINGS ACTION SHOLD BE 08/11 CECKCOMERCETINA ACTION SHOLD BE 08/11 CECKCOMERCETINA ACTION SHOLD BE 09/12 CECKCOMERCETINA ACTION SHOLD BE 09/13 CECKCOMERCETINA ACTION SHOLD BE 09/14 SHOLD STREEMENT ACTION SHOLD BE 09/15 CERCICINA ACTION SHOLD BE 09/16 CERCICINA ACTION SHOLD BE 00/17 CERCICINA ACTION SHOLD BE 00/17 CERCICINA ACTION SHOLD BE 00/17 CERCICINA ACTION SHOLD BE 10/16 SHOLD AND ACTION SHOLD BE 11/16 SHOLD AND ACTION SHOLD BE 11/16	TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	included and	0.0938-
WALE OF PROVIDER OR SUPPLIER STREETADRESS, CITY, STATE, ZP CODE AAURA SPRINGS ROAD HOME SURMARY STATEMENT OF DEFICIENCIES 04100 SURMARY STATEMENT OF DEFICIENCIES 04101 SURMARY STATEMENT OF DEFICIENCIES 04102 SURMARY STATEMENT OF DEFICIENCIES 04101 SURMARY STATEMENT OF DEFICIENCIES 04101 SURMARY STATEMENT OF DEFICIENCIES 04101 SURMARY STATEMENT OF DEFICIENCIES 04102 SURMARY STATEMENT OF DEFICIENCIES 04101 SURMARY STATEMENT OF DEFICIENCIES 0411 SURMARY STATEMENT OF DEFICIENCIES 04011 SURMARY STATEMENT OF DEFICIE	NU PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:				
AURA SPRINGS ROAD HOME STREET ADDRESS, CITY, STRTL 2P CODE JURA SPRINGS ROAD HOME SUMMARY STRTLEP TO DESCREPTOR TALL PRETR EACH DEFICIENCY MISTE DEPECTION OF DESCREPTOR TALL PRETR EACH DEFICIENCY MISTE DEPECTION OF DESCREPTOR TALL PRETR EACH DEFICIENCY MISTE DEPECTION OF DESCREPTOR TALL PRETR PREGULATORY OR LSC IDENTIFYING INFORMATION PRETR PRECULATORY OR LSC IDENTIFYING INFORMATION E 004 Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) \$411.744(a) \$406.41(a), \$402.15(a), \$483.73(a), \$485.42(a), \$485.625(a), \$485.727(a), \$485.542(a), \$485.625(a), \$485.727(a), \$485.542(a), \$485.625(a), \$485.727(a), \$485.542(a), \$485.625(a), \$485.727(a), \$485.625(a), \$485.625(a), \$485.727(a), \$486.625(a), \$485.625(a), \$485.727(a), \$486.625(a), \$485.625(a), \$485.727(a), \$485.625(a), \$485.625(a), \$485.727(a), \$486.625(a), \$485.625(a), \$485.727(a), \$486.625(a), \$485.727(a), \$486.625(a), \$485.727(a), \$486.625(a), \$485.727(a), \$486.625(a), \$485.727(a), \$486.625(a), \$485.727(a), \$486.625(a), \$485.727(a), \$486.625(a), \$485.727(a), \$486.625(a), \$486.727(a), \$486.625(a), \$486.727(a), \$486.625(a), \$485.727(a), \$486.625(a), \$486.727(a), \$486.625(a), \$486.727(a), \$486.625(a), \$487.72(a), \$486.625(a), \$487.72(a), \$486.625(a), \$486.727(a), \$486.625(a), \$487.72(a), \$486.625(a), \$486.727(a), \$486.625(a), \$486.727(a), \$486.625(a), \$487.72			34G051	B. WING		06/40/000	
PREFIX (EACH DEPICIENCY MUST BE PRECEDED BY YULL REGULATORY OR LS: IDENTIFYING APROMATION) PREFIX TXG CENTROPRESENTION OF MUST BE PRECEDED BY YULL REGULATORY OR LS: IDENTIFYING APROMATION) PREFIX TXG E 004 Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) E 004 E 004 \$403.748(a), \$446.54(a), \$418.113(a), \$441.148(a), \$460.84(a), \$423.73(a), \$443.475(a), \$446.9(a), \$428.727(a), \$445.542(a), \$445.625(a), \$448.727(a), \$445.542(a), \$445.625(a), \$448.727(a), \$445.542(a), \$445.626(a), \$448.727(a), \$445.542(a), \$445.716(a), \$441.12(a), \$447.148(b), \$460.848(b), \$441.12(a), \$447.148(b), \$460.848(b), \$441.12(a), \$447.148(b), \$460.848(b), \$442.150(b), \$442.148(b), \$447.148(b), \$440.148(b), \$447.148(b), \$440.148(b), \$441.148(b), \$440.148(b), \$443.73(a), \$441.148(b), \$440.148(b), \$443.73(a), \$441.148(b), \$440.148(b), \$443.73(a), \$441.148(b), \$440.148(b), \$443.73(a), \$441.148(b), \$441.148(b), \$443.73(a), \$441.148(b), \$441.148(b), \$443.73(a), \$441.148(b), \$443.73(a), \$441.148(b), \$441.148(b), \$443.73(a), \$441.148(b), \$440.148(b), \$443.73(a), \$441.148(b), \$440.148(b), \$443.73(a), \$441.148(b), \$443.73(a), \$441.148(b), \$441.148(b), \$443.73(a), \$441.148(b), \$441.148(PRINGS ROAD HOME		309	LAURA SPRINGS DR	06/10/202	
CFR(s): 483.475(a) \$403.748(a), \$416.54(a), \$418.113(a), \$441.184(a), \$400.84(a), \$482.15(a), \$483.73(a), \$483.475(a), \$484.702(a), \$485.68(a), \$485.542(a), \$485.625(a), \$485.727(a), \$485.320(a), \$485.60(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 \$486.625(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. * [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.	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLE
A DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	F a a f	CFR(s): 483.475(a §403.748(a), §416. §441.184(a), §460. §483.475(a), §484. §485.542(a), §484. §485.542(a), §485. §494.62(a). The [facility] must c Federal, State and I preparedness requi develop establish a emergency prepare requirements of this preparedness progr limited to, the follow (a) Emergency Plan and maintain an em that must be [review every 2 years. The following: * [For hospitals at §4 §485.625(a):] Emerge CAH] must comply v State, and local eme equirements. The [develop and maintai emergency prepared equirements of this all-hazards approach [For LTC Facilities a Plan. The LTC facility in emergency prepared eviewed, and update	 54(a), §418.113(a), 84(a), §482.15(a), §483.73(a), 102(a), §485.68(a), 625(a), §485.727(a), 360(a), §491.12(a), omply with all applicable local emergency rements. The [facility] must nd maintain a comprehensive dness program that meets the section. The emergency am must include, but not be ing elements: The [facility] must develop ergency preparedness plan wet do all of the 482.15 and CAHs at gency Plan. The [hospital or vith all applicable Federal, ergency preparedness hospital or CAH] must n a comprehensive dness program that meets the section, utilizing an n. at §483.73(a):] Emergency / must develop and maintain redness plan that must be ed at least annually.				

Ar 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.

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G051	B. WING		06/10/2025	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 309 Laura Springs dr Salisbury, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
E 004	* [For ESRD Facilities Plan. The ESRD facilities Plan. The ESRD facili maintain an emergen must be [evaluated], a years. This STANDARD is r Based on record revi failed to provide an up preparedness plan (E Review of records dur survey revealed no ev home EPP manual. C for the same survey p manual with "Rockwe review. Further review	s at §494.62(a):] Emergency ity must develop and cy preparedness plan that and updated at least every 2 not met as evidenced by: www.and.interview, the facility odate for the emergency PP) manual. The finding is: ring the 6/9/25 - 6/10/25 vidence of an update to the continued review of records veriod revealed an EPP II" name presented for w of records revealed the turned as it was not the	E 004	E004 The Qualified Professional w the EPP for Laura Springs is home and available to all sta in-service all staff on the EP clinical team will monitor thm environmental assessments week for a period of 30 days on a routine basis to ensure is available in the home to a the future, the qualified profe will ensure the EPP is in the and trained to all staff.	s in the aff and will P. The ough 1x a and then the EPP Il staff. In essional	8/9/25
	disabilities professiona facility has no evidence or actual manual. Subsistence Needs for CFR(s): 483.475(b)(1) §403.748(b)(1), §418. (1), §460.84(b)(1), §418. (1), §460.84(b)(1), §485. [(b) Policies and proce develop and implement policies and procedure plan set forth in paragra		E 015			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RUP611

Facility ID: 922107

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PRINTED: 06/17/2025 FORM APPROVED

STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY COMPLETED	
		34G051	B. WING				0/40/000
LAURA S	PROVIDER OR SUPPLIER			309	EET ADDRESS, CITY, STATE, ZIP CODE LAURA SPRINGS DR -ISBURY, NC 28144		06/10/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D BE	(X5) COMPLETION DATE
	 this section. The policible reviewed and updation LTC facilities]. At a procedures must addred (1) The provision of su and patients whether the place, include, but are (i) Food, water, medicates supplies (ii) Alternate sources of following: (A) Temperatures to provisions. (B) Emergency lighting. (C) Fire detection, extinations, (D) Sewage and waste *[For Inpatient Hospice Policies and procedures (6) The following are ad hospice-operated inpation The policies and procedures (fillowing: (iii) The provision of sub hospice employees and 	ies and procedures must ted every 2 years [annually minimum, the policies and ess the following: bisistence needs for staff ney evacuate or shelter in not limited to the following: and pharmaceutical f energy to maintain the btect patient health and and sanitary storage of guishing, and alarm disposal. at §418.113(b)(6)(iii):] s. ditional requirements for ent care facilities only. lures must address the sistence needs for patients, whether they ace, include, but are not I, and pharmaceutical energy to maintain the ect patient health and	ΕO	915			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		O. 0938-03
ND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G051	B. WING		06/10/2025	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		TOLOLO
LAURA S	PRINGS ROAD HOME		3	809 LAURA SPRINGS DR		
			5	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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
E 015	 (3) Fire detection, ext systems. (C) Sewage and wast This STANDARD is r Based on observation failed to ensure its pro- for staff and clients sp supplies and foods we is: Observations in the gr revealed the facilities contain a variety of ex the following: canned 12/24, 03/25, 05/25, s 03/25, chocolate pudo cereal bars - 01/25, ch 	inguishing, and alarm e disposal. tot met as evidenced by: in and interview the facility povision of subsistence needs tecific to evacuation are maintained. The finding roup home on 6/9/25 emergency food supplies to pired products to include goods ranging from 09/24, trawberry snack packs - lings cups - 04/25, 30 count meddar crackers 09/24, and	E 015	E 015 The Program Manager will the Home Manager on eme food supplies and ensuring emergency foods are kept i The clinical team will monito environmental assessments week for a period of 30 day on a routine basis. In the fur home manager will ensure a emergency foods are kept w	rgency n date. or through s 1x a s and then ture, the all	8/9/25
E 039	 cereal bars - 01/25, cheddar crackers 09/24, and honey graham crackers - 11/24. Interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) revealed she was not aware of the expired foods in the emergency food container. Further interview with the QIDP confirmed the foods and other items should be kept current and monitored ensuring expired goods are discarded and replaced. EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §485.542(d)(2), §485.625(d)(2), §485.68(d)(2), §485.542(d)(2), §491.12(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at 		E 039			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: RUP611

Facility ID: 922107

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2025 FORM APPROVED OMB NO: 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		O. 0938-039 E SURVEY IPLETED
		34G051	B. WING		06	6/10/2025
	Rovider or supplier			STREET ADDRESS, CITY, STATE, ZIP CODE 309 LAURA SPRINGS DR SALISBURY, NC 28144		10/2023
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	 §491.12, and ESR (2) Testing. The [fat to test the emerger must do all of the fat (i) Participate in a f community-based of (A) When a comm accessible, conduct exercise every 2 yet (B) If the [facili natural or man-mad activation of the emerger exempt from engage community-based of functional exercise actual event. (ii) Conduct an add years, opposite the functional exercise this section is condi- not limited to the fol (A) A second full-so community-based of functional exercise; (B) A mock disaster (C) A tabletop exercise a facilitator and incli a narrated, clinically scenario, and a set directed messages, designed to challent (iii) Analyze the [fac maintain documenta) 	D Facilities at §494.62]: cility] must conduct exercises not plan annually. The [facility] ollowing: full-scale exercise that is every 2 years; or unity-based exercise is not at a facility-based functional ears; or ty] experiences an actual de emergency that requires nergency plan, the [facility] is jing in its next required or individual, facility-based following the onset of the itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: cale exercise that is or individual, facility-based or or drill; or cise or workshop that is led by udes a group discussion using <i>r</i> -relevant emergency of problem statements, or prepared questions ge an emergency plan. ility's] response to and ation of all drills, tabletop rgency events, and revise the	E 039	E039 The Qualified Professional and Safety Chairperson will update Emergency Preparedness Plan Qualified Professional will train staff on the plan. The Regional Administrator will monitor the Emergency Preparedness Plan 6 months to ensure it remains updated and staff are trained. T Program Manager and Safety Chairperson will organize and complete a tabletop exercise. Th Safety Chairperson will monitor ensure tabletop exercises are completed at least on an annual basis. In the future, the Regional Administrator will ensure tableto exercises are completed on an annual basis. The Qualified Professional will ensure the Emergency Preparedness Plan updated and staff are trained on current plan and training conduct annually.	The all every he to I p is the	8/9/25

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Facility ID: 922107

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/17/2025 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DA	NO: 0938-039 TE SURVEY MPLETED
		34G051	B. WING			6/10/2025
	PROVIDER OR SUPPLIER		309	EET ADDRESS, CITY, STATE, ZIP CODE LAURA SPRINGS DR LISBURY, NC 28144		0/10/2025
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	*[For Hospices at 4 (2) Testing for hospication of the service of	18.113(d):] Dices that provide care in the e hospice must conduct e emergency plan at least bice must do the following: full-scale exercise that is every 2 years; or nity based exercise is not an individual facility based every 2 years; or compare the hospital is exempt from required full scale xercise or individual bonal exercise following the ency event. itional exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section hay include, but is not limited ency everts is r a facility based functional	E 039			

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Event ID: RUP611

Facility ID: 922107

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ENTERS FOR MEDICARE & MEDICAID SERVICES

OLIVILI	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	0.0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G051	B. WING			06	6/10/2025
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00	10/2025
					AURA SPRINGS DR		
LAURA S	PRINGS ROAD HOME				ISBURY, NC 28144		
(2/4) 10	CUMMADY OT			UAL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	is community-based; (A) When a communi accessible, conduct a facility-based function (B) If the hospice exp man-made emergency the emergency plan, it engaging in its next re based or facility-base following the onset of (ii) Conduct an additi may include, but is no (A) A second full-sca community-based or a exercise; or (B) A mock disaster of (C) A tabletop exercise facilitator that includes narrated, clinically-rela and a set of problem s messages, or prepare challenge an emerger (iii) Analyze the hosp maintain documentative exercises, and emerger (iii) Analyze the hosp maintain documentative exercises, and emerger (iii) Analyze the hosp maintain documentative exercises and emerger (iii) Conduct exercises to t twice per year. The [PRTI conduct exercises to t twice per year. The [PRTI do the following: (i) Participate in an ar is community-based; of	or ty-based exercise is not in annual individual nal exercise; or eriences a natural or by that requires activation of the hospice is exempt from equired full-scale community d functional exercise the emergency event. Onal annual exercise that of limited to the following: le exercise that is a facility based functional drill; or se or workshop led by a s a group discussion using a evant emergency scenario, statements, directed ad questions designed to noy plan. ice's response to and on of all drills, tabletop ency events and revise the plan, as needed. 184(d), Hospitals at S485.625(d):] F, Hospital, CAH] must est the emergency plan PRTF, Hospital, CAH] must nnual full-scale exercise that or y-based exercise is not	E	039			

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Event ID: RUP611

Facility ID: 922107

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		34G051	B. WING		0	6/10/2025
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE 309 LAURA SPRINGS DR SALISBURY, NC 28144		0/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
	facility-based functio (B) If the [PRTF, Hos actual natural or mar requires activation of [facility] is exempt fro required full-scale co facility-based function onset of the emerger (ii) Conduct an and that may include following: (A) A second full-sca community-based or functional exercise; of (B) A mock (C) A tabletop ex- led by a facilitator and discussion, using a n emergency scenario, statements, directed questions designed to plan. (iii) Analyze the [maintain documentati exercises, and emerge [facility's] emergency *[For PACE at §460.8 (2) Testing. The PACE exercises to test the e annually. The PACE of following: (i) Participate in an an is community-based; (A) When a communit accessible, conduct a facility-based function	nal exercise; or spital, CAH] experiences an n-made emergency that the emergency plan, the om engaging in its next mmunity based or individual, hal exercise following the ney event. (additional] annual exercise or , but is not limited to the ale exercise that is individual, a facility-based r disaster drill; or sercise or workshop that is d includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency facility's] response to and on of all drills, tabletop ency events and revise the plan, as needed. 4(d):] e organization must conduct emergency plan at least organization must do the nnual full-scale exercise that for y-based exercise is not n annual individual,	E 039			

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PRINTED: 06/17/2025 FORM APPROVED

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB	NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		NSTRUCTION		TE SURVEY MPLETED
		34G051	B. WING			0	6/10/2025
	Rovider or supplier PRINGS ROAD HOME			309 L	ET ADDRESS, CITY, STATE, ZIP CODE AURA SPRINGS DR SBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
E 039	the emergency plan, engaging in its next m based or individual, fr exercise following the event. (ii) Conduct an a years opposite the years exercise under parage is conducted that may the following: (A) A second full-sca community-based or functional exercise; o (B) A mock disaster (C) A tabletop exerci- a facilitator and include using a narrated, clini- scenario, and a set of directed messages, of designed to challenge (iii) Analyze the PAC maintain documentati exercises, and emerge PACE's emergency p including unannounce emergency procedure (CF/IID] must do the f (i) Participate in an a is community-based; (A) When a communi-	ey that requires activation of the PACE is exempt from equired full-scale community acility-based functional a onset of the emergency dditional exercise every 2 ear the full-scale or functional raph (d)(2)(i) of this section y include, but is not limited to le exercise that is individual, a facility based r drill; or se or workshop that is led by des a group discussion, cally-relevant emergency f problem statements, r prepared questions a an emergency plan. E's response to and on of all drills, tabletop tency events and revise the lan, as needed. s §483.73(d):] must conduct exercises to an at least twice per year, ed staff drills using the es. The [LTC facility, following: nnual full-scale exercise that or ty-based exercise is not n annual individual,	E	039			

FORM CMS-2567(02-99) Previous Versions Obsolete

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES				OMB	NO. 0938-039
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G051	B. WING			0// 0/0000
NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	0	6/10/2025
LAURA S	PRINGS ROAD HOME			9 LAURA SPRINGS DR		
				ALISBURY, 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 CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	actual natural or man- requires activation of LTC facility is exempt required a full-scale c individual, facility-base following the onset of (ii) Conduct an addition may include, but is no (A) A second full-scale community-based or a functional exercise; or (B) A mock disaster d (C) A tabletop exercise a facilitator includes a narrated, clinically-relea and a set of problem s messages, or prepared challenge an emergen (iii) Analyze the [LTC facility] facility's e *[For ICF/IIDs at §483. (2) Testing. The ICF/IID to test the emergency f The ICF/IID must do th (i) Participate in an anr is community-based; or (A) When a community accessible, conduct an facility-based functiona (B) If the ICF/IID experi-	-made emergency that the emergency plan, the from engaging its next ommunity-based or ed functional exercise the emergency event. onal annual exercise that t limited to the following: e exercise that is in individual, facility based rill; or e or workshop that is led by group discussion, using a evant emergency scenario, tatements, directed d questions designed to cy plan. facility] facility's response to itation of all drills, tabletop ency events, and revise the mergency plan, as needed. 475(d)]: D must conduct exercises olan at least twice per year. e following: nual full-scale exercise that r -based exercise is not annual individual, I exercise; or. ences an actual natural or that requires activation of e ICF/IID is exempt from uired full-scale dividual, facility-based	E 039			

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Event ID: RUP611

Facility ID: 922107

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ISTRUCTION	(X3) DAT	TE SURVEY MPLETED
		34G051	B. WING				6/10/2025
	ROVIDER OR SUPPLIER PRINGS ROAD HOME			309 LA	T ADDRESS, CITY, STATE, ZIP CODE Aura springs dr BBURY, NC 28144		0/10/2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	may include, but is no (A) A second full-scal community-based or functional exercise; o (B) A mock disaster of (C) A tabletop exercise a facilitator and includ using a narrated, clini scenario, and a set of directed messages, o designed to challenge (iii) Analyze the ICF/II maintain documentati exercises, and emerge ICF/IID's emergency ICF/IID's emergency *[For HHAs at §484.1 (d)(2) Testing. The HH to test the emergency least annually. The H (i) Participate in a full- community-based; or (A) When a comm accessible, conduct a facility-based function or. (B) If the HHA ex or man-made emerge of the emergency plan engaging in its next re community-based or i functional exercise fol emergency event. (ii) Conduct an additic opposite the year the	onal annual exercise that of limited to the following: le exercise that is an individual, facility-based r Irill; or se or workshop that is led by des a group discussion, ideally-relevant emergency f problem statements, or prepared questions a an emergency plan. ID's response to and ion of all drills, tabletop pency events, and revise the plan, as needed. 02] HA must conduct exercises or plan at HA must do the following: escale exercise that is munity-based exercise is not n annual individual, ial exercise every 2 years; experiences an actual natural incy that requires activation n, the HHA is exempt from equired full-scale ndividual, facility based lowing the onset of the anal exercise every 2 years,	E	039			

CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G051	B. WING		06/	10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 039	limited to the following (A) A second full- community-based or a functional exercise; of (B) A mock disas (C) A tabletop ex- led by a facilitator and discussion, using a na emergency scenario, statements, directed r questions designed to plan. (iii) Analyze the HHA's documentation of all d emergency events, ar emergency plan, as na *[For OPOs at §486.3] (d)(2) Testing. The OF to test the emergency following: (i) Conduct a paper-ba- workshop at least ann led by a facilitator and discussion, using a na emergency scenario, a statements, directed n questions designed to plan. If the OPO experi- man-made emergency the emergency plan, the engaging in its next re following the onset of f (ii) Analyze the OPO's documentation of all tables	t may include, but is not g: -scale exercise that is an individual, facility-based ter drill; or ercise or workshop that is l includes a group arrated, clinically-relevant and a set of problem messages, or prepared o challenge an emergency s response to and maintain trills, tabletop exercises, and id revise the HHA's eeded. 60] PO must conduct exercises plan. The OPO must do the ased, tabletop exercise or ually. A tabletop exercise is includes a group rrated, clinically relevant and a set of problem messages, or prepared challenge an emergency riences an actual natural or v that requires activation of ne OPO is exempt from quired testing exercise the emergency event. response to and maintain abletop exercises, and d revise the [RNHCI's and	E 035			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY		
	DENTROATON NUMBER.		A. BUILDING	3		PLETED	
NAME OF		34G051	B. WING		0	6/10/2025	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COU 309 LAURA SPRINGS DR SALISBURY, NC 28144	DE	0/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
E 039	*[RNCHIs at §403.7	48]:	E 03	9			
	 (d)(2) Testing. The R exercises to test the must do the following (i) Conduct a paper-ti- least annually. A tabil discussion led by a fa- clinically-relevant em- of problem statement prepared questions di emergency plan. (ii) Analyze the RNH0 maintain documentat and emergency even emergency plan, as n This STANDARD is n Based on record revis failed to conduct bien emergency prepared finding is: 	NHCI must conduct emergency plan. The RNHCI g: based, tabletop exercise at etop exercise is a group acilitator, using a narrated, ergency scenario, and a set ts, directed messages, or lesigned to challenge an CI's response to and ion of all tabletop exercises, ts, and revise the RNHCI's needed. not met as evidenced by: iew and interview, the facility nial testing of the facility's ness plan (EPP). The					
-	no evidence of a full-s facility-based training,	a second full acility-based training or					
W 104	disabilities profession facility has no evidenc community or facility-k		W 104				
	The governing body m	ust exercise general policy,					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G051	B. WING		0	6/10/2025
	Rovider or Supplier	1		STREET ADDRESS, CITY, STATE, ZIP CODE 309 LAURA SPRINGS DR SALISBURY, NC 28144		5/10/2025
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
W 104	budget, and opera This STANDARD Based on observations interviews, the gow failed to exercise go direction over the f facility repairs were is: Observations in the survey period from clients to use two b grooming in the gro observations revea the toilet seat safet observation in the gro the home's dining in require sanding an recliner in the living leather; and a dinin	age 13 ting direction over the facility. is not met as evidenced by: tition, record review and terning body and management general policy and operating acility by failing to assure a conducted timely. The finding be group home during the 6/9/25 - 6/10/25 revealed all both potentiation bathing and boup home. Continued led both bathrooms to have by rails rusted. Subsequent group home revealed walls in oom and living room that d paint; a love seat and groom with peeling and torn ig room table that has several aint is peeling off the top	W 104	DEFICIENCY)	8/9/25	
surface. Interview with staff B on 6/9/25 revealed have made management aware of the needed replacing in the home via the p of work orders, but they were uncertain status of the work orders. Interview with the qualified intellectual professional (QIDP) on 6/10/25 revealed management were aware of the furnitu walls needing to be replaced and paint interview the QIDP revealed managem placing orders for replacement furnishi they could not provide invoices for thos W 195 ACTIVE TREATMENT SERVICES CFR(s): 483.440	ement aware of the items that in the home via the placement they were uncertain of the orders. ualified intellectual disabilities) on 6/10/25 revealed she and aware of the furniture and replaced and painted. Further revealed management to be eplacement furnishings, but ide invoices for those.	W 195				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		E SURVEY
	OURREUTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		34G051	B. WING		06	/10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAURA SI	PRINGS ROAD HOME			309 LAURA SPRINGS DR		
				SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
W 195	Continued From page	ge 14	W 195	W195		7/25/25
t a ((The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: The team failed to: ensure the interdisciplinary team completed preliminary accurate assessments within 30 days after admission (W210); and ensure the person-centered plan (PCP) was developed and implemented within 30 days of admission for 1 newly admitted client (W226).			The program manager will in the qualified professional on the PCP is completed within of admission with all assess The program manager will m	ensuring 30 days nents.	
				PCPs every month to ensure completed and signed by the Administrator. In the future, the program manager will ensure qualified professional complet with assessments for new ad within 30 days of admission.	they are Regional he the the PCPs	
	resulted in the facilit	ct of these systemic practices y's failure to provide active treatment services to				
W 196	ACTIVE TREATMEN CFR(s): 483.440(a)(W 196			
Each client must red treatment program, consistent impleme specialized and gen services and related subpart, that is dired (i) The acquisition the client to function determination and ir (ii) The prevention		of the behaviors necessary for				
	Based on observation	not met as evidenced by: ons, record review and ews with staff, the facility				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTER	S FOR WEDICARE &	MEDICAID SERVICES			OWB NO	0.0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G051	B. WING		06	/10/2025
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				309 LAURA SPRINGS DR		
LAURA SI	PRINGS ROAD HOME			SALISBURY, NC 28144		
				SALISBURT, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
			1			7/25/25
W 196	Continued From page	e 15	W 196	5		1120120
	failed to provide an a	ggressive implementation of		14/400		
		to 1 of 6 audited clients (#3)		W196		
		ng preliminary accurate		A & B		
				Cross reference W195		
		ing to develop an accurate				
	PCP within 30 days o	r admission.				
		V210. The interdisciplinary				
		te preliminary accurate				
	assessments within 3	0 days of admission for 1				
	newly admitted client.					
	B Cross reference W	V226. The facility failed to				
		ntered plan (PCP) was				
		mented within 30 days of				
	admission for 1 newly					
W 210	INDIVIDUAL PROGR		W 210	W210		
	CFR(s): 483.440(c)(3)		VV210		7/25/25
	Within 30 days after a	admission, the		The program manager will in-serv		
		must perform accurate		the qualified professional on ensu	ring	
		sessments as needed to		all assessments for new admissio	ns	
		ninary evaluation conducted		are completed within 30 days of		
	prior to admission.	inary evaluation conducted		admission. The clinical team will		
		et met as suideneed bu		monitor through chart reviews		
		not met as evidenced by:		quarterly and on a routine basis.	n	
		ew and interview, the facility		the future, the program manager		
	failed to ensure the in					
		accurate assessments		ensure all qualified professionals	are	
	-	dmission. This affected 1		trained on the new admission		
	newly admitted audit	client (#3). The finding is:		process.		
	Review of client #3's i	record revealed he was				
	admitted to the facility	on 4/29/25. Further review				
		evealed his person centered				
		as held on 5/20/25. Review				
		ary evaluations revealed he				
		n evaluation, eye exam,	1.			
	hearing exam, speech					
	psychological evaluat	ion and an adaptive				
						0.000 0000 000000

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Event ID: RUP611

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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S FOR MEDICARE &	MEDICAID SERVICES			OMB	IO. 0938-0391
OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
	34G051	B. WING		0	6/10/2025
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/10/2020
DINCE DOAD HOME			309 LAURA SPRINGS DR		
PRINGS ROAD HOME			SALISBURY, NC 28144		
(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
behavior inventory (Al Interview on 6/10/25 w disabilities professional assessments had been interview with the QID not received the assess consultants and were Continued interview w all assessments should days after admission f INDIVIDUAL PROGR/ CFR(s): 483.440(c)(4) Within 30 days after and interdisciplinary team of client, an individual pro- This STANDARD is no Based on observation interview, the facility far admitted client (#3) rece plan (PCP) within 30 d finding is: Review on 6/9/25 - 6/11 revealed he was admit 4/29/25 and that his per meeting was held on 5 Observations during the revealed client #3 to par activities, breakfast and himself, taking his dish place in the dishwasher	31) assessment. with the qualified intellectual al (QIDP) revealed a few n completed. Further P revealed the facility had assments from the not available for review. ith the QIDP revealed that d be completed within 30 or all clients. AM PLAN dmission, the must prepare, for each ogram plan. ot met as evidenced by: s, record review and wiled to ensure 1 newly ceived an person-centered ays after admission. The 0/25 of client #3's record ted to the facility on erson centered plan /20/25. e 6/9/25 - 6/10/25 survey articipate in leisure d dinner meals by serving es to the sink, rinse then r as well as wiping his		0		7/25/25
	OF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER PRINGS ROAD HOME SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From page behavior inventory (AI Interview on 6/10/25 v disabilities professiona assessments had bee interview with the QID not received the asses consultants and were Continued interview w all assessments shoul days after admission ff INDIVIDUAL PROGR/ CFR(s): 483.440(c)(4) Within 30 days after ad interdisciplinary team f client, an individual pro This STANDARD is no Based on observation interview, the facility fa admitted client (#3) rec plan (PCP) within 30 d finding is: Review on 6/9/25 - 6/1 revealed he was admit 4/29/25 and that his per meeting was held on 5 Observations during th revealed client #3 to pa activities, breakfast any himself, taking his dish place in the dishwashe space at the table. Mec observations at 7:40 A	FORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 behavior inventory (ABI) assessment. Interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) revealed a few assessments had been completed. Further interview with the QIDP revealed the facility had not received the assessments from the consultants and were not available for review. Continued interview with the QIDP revealed that all assessments should be completed within 30 days after admission for all clients. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) Within 30 days after admission, the interdisciplinary team must prepare, for each client, an individual program plan. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure 1 newly admitted client (#3) received an person-centered plan (PCP) within 30 days after admission. The	OP DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING 34G051 B. WING	OP DEFICIENCIES CORRECTION [X1] PROVIDER/SUPPLIERCULA IDEMTIFICATION NUMBER: [X2] MULTIPLE CONSTRUCTION A BUILDING 34G051 S. WING ROVIDER OR SUPPLIER PRINGS ROAD HOME STREET ADDRESS, CITY, STATE, ZIP CODE 309 LAURA SPRINGS DR SALISBURY, NC 2 8144 SUMMARY STREMENT OF DEFICIENCIES (EACH FOR PERCIENC) WERE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX LEACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APPLICE REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX LEACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APPLICE INFORMATION FORSIONAL (QIDP) revealed a few assessments had been completed. Further Interview with the QIDP revealed that all assessments should be completed. Further Interview with the QIDP revealed that all assessments should be completed within 30 days after admission for all clients. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) W 226 Within 30 days after admission, the Interview with a CollDP revealed that all assessments should be consulted within 30 days after admission, the Interview, the facility fuel charding lis: W 226 Within 30 days after admission, the Interview with the QIDP revealed that all assessments should be consulted within 30 days after admission, the Interview, the facility failed intellectual diversion, record review and linerview, the facility failed the ability on 4/29/25 and that his person centered plan (PCP) within 30 days after admission. The finding is: W 226 Review on 6/9/25 - 6/10/25 of client #3's record revealed client #3 to participate in leisure activities, breakfast and dinner meals by serving himsef, taking his dishes to the sink, rinse then place in the dictaving the facility an hadicitica, at 7:40 AM revealed, client #3 was	OPCENDENSITY (M) PROVIDERSUPPLICATION NUMBER: A BUILDING (M) PROVIDERSUPPLICATION NUMBER: A BUILDING (M) COL STREETADORES, CITY, STATE, ZP CODE 34G051 B. WING 0 ROVIDER OR SUPPLIER STREETADORESS, CITY, STATE, ZP CODE 30 LAURA SPRINGS DR PRINGS ROAD HOME STREETADORESS, CITY, STATE, ZP CODE 30 LAURA SPRINGS DR SUMMARY STATEMENT OF DEPICIENCES ID PROVIDER'S PLAN OF CORRECTION (EXC) TOFFICIENCY MUST BE PRECEDED BY FULL ID PROVIDER'S PLAN OF CORRECTION (EXC) CORRECTIVE ACTION STATEMENT OF DEPICIENCES ID PROVIDER'S PLAN OF CORRECTION (EXC) CORRECTIVE ACTION SHOULD BE UD CAURA SPRINGS DR SALISBURY, NC 28144 W 210 PREFIX Continued From page 16 W 210 V210 Dehavior inventory (ABI) assessment. W 210 W 210 Interview on 6/10/25 with the qualified intellectual disabilities professional (QIDP) revealed that all assessments should be completed. Further interview with the QIDP revealed that all assessments should be completed. Within 30 days after admission for all clients. W 226 CFR(s): 483.440(c)(4) W 226 Cross reference W210 Within 30 days after admission. The finding is: Review on 6/9/25 - 6/10/25 oreiewait an emony ad

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0	938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SU COMPLET	
		34G051	B. WING		06/10/	2025
	PROVIDER OR SUPPLIER		309	REET ADDRESS, CITY, STÂTE, ZIP CODE D LAURA SPRINGS DR LISBURY, NC 28144		2025
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE C	(X5) OMPLETION DATE
W 226	client to have his glue reading was "166" fo Review of client #3's lists client's diet as re the group home, his consistency, regular 2	cose level checked and the llowing the breakfast meal. physician order on 6/10/25 gular diabetic, however in diet is listed as whole 2,000 calorie diet.	W 226			
W 472	(PM) revealed no PC Further interview on 6 intellectual disabilities revealed no PCP has few assessments hav Continued interview v the survey exit on 6/1 provide the surveyors admission. MEAL SERVICES	been developed, and only a re been developed. with the QIDP right before 0/25 revealed the QIDP to a PCP based on a previous	W 472			
	This STANDARD is n Based on observation interviews, the facility served in the appropri for 3 of 6 audit clients findings are:	in appropriate quantity. not met as evidenced by: ns, record reviews, and failed to ensure food was ate quantity as prescribed (#2, #3 and #6). The				
	prescribed. For examp During observation in 5:30 PM, client #2 was which consisted of one cup of mashed potatoo	ble: the home on 6/10/25 at s observed eating dinner e 4 oz baked pork chop, ½				

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING			E SURVEY PLETED
		34G051	B. WING		06	/10/2025
	ROVIDER OR SUPPLIER		309	REET ADDRESS, CITY, STATE, ZIP CODE) LAURA SPRINGS DR .LISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETIC DATE
W 472	Continued observati himself more than the with hand over hand observation revealed chop, mashed potate Review of client #2's person-centered play revealed a weight lo- excessive weigh gain B. The facility failed the appropriate quar prescribed. For exar During observations 5:30 PM, client #3 we which consisted of of cup of mashed potate vegetables, 1 biscuit lemonade, almond in Continued observation himself at least 1 cup potatoes. Further ob to consume his dinner During observations 7:00 AM, client #3 we which consisted of 1 scrambled egg, orand a bowl of peaches. Consume his dinner portion of scrambled already in the bowl. client #3 to eat all of Review of client #3's	hilk, 2% milk and water. on revealed client #2 to serve the ½ cup of mashed potatoes assistance. Further d client #2 to eat the pork bes and biscuit in its entirety. a records revealed a in (PCP) dated 6/4/24 ss ¼ consistency diet due to n. to assure food was served in http for client #3 as inple: in the home on 6/9/25 at as observed eating dinner ne 4 oz baked pork chop, ½ toes, ½ cup of mixed c, sugar free punch and hilk, 2% milk and water. on revealed client #3 to serve o or more of the mashed servation revealed client #3 er meal in its entirety. in the home on 6/10/25 at as observed eating breakfast cup of oatmeal, 1 serving of nge juice, 2% milk, water and Continued observation serve himself double the leggs; the oatmeal was Further observation revealed his breakfast in its entirety.	W 472	W472 A. B. C. The qualified professional will in-service all staff on diet order People Supported to ensure a re followed as prescribed. The clinical team will monitor throo meal time assessments 1x a for 30 days and then on a rou basis to ensure diet orders ar followed as prescribed. In the the qualified professional will all staff are trained on diet order People Supported.	ers of hey ugh week tine e being future, ensure	8/9/25

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G051	B. WING			06	/10/2025
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 309 LAURA SPRINGS DR SALISBURY, NC 28144	, CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE	CTION SHOULD B		(X5) COMPLETION DATE
W 472 W 474	a regular diabetic die C. The facility failed the appropriate quant prescribed. For exam During observations in 5:30 PM, client #6 was which consisted of a ½ cup of mashed pot vegetables, 1 biscuit, lemonade, almond m Continued observation himself at least 1 cup potatoes. Further observation loss (1500 calories) H Diabetes Mellitus (DM Interview on 6/10/25 of disabilities profession diets for client's #2, # Further interview with clients should have b food indicated on the their respective diet of with the QIDP revealed clients' prescribed died MEAL SERVICES CFR(s): 483.480(b)(2 Food must be served developmental level of	t. to assure food was served in tity for client #6 as ple: In the home on 6/10/25 at is observed eating dinner one 4 oz baked pork chop, atoes, ½ cup of mixed sugar free punch and ilk, 2% milk and water. In revealed client #6 to serve or more of the mashed servation revealed client #3 r meal in its entirety. The cords revealed a ht (NA) dated 4/15/25 that tency ground meats, weight deart Healthy, thin liquids, A), diet. With the qualified intellectual al (QIDP) confirmed the 3 and #6' are current. The QIDP confirmed that all een served the amount of menu and as prescribed per orders. Continued interview ed staff should follow the ets during mealtimes.	W 4				

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Event ID: RUP611

Facility ID: 922107

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		34G051	B. WING		06	6/10/2025
	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 309 Laura springs dr SALISBURY, NC 28144		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 474	Based on observation interview, the facility served in a form considered opmental level The findings is: During observations 7:00 AM, client #4 was which consisted of oa orange juice, 2% mill peaches. The scram served in whole form whole form. Review on 6/10/25 of assessment (NA) dat order consisting of put snacks, alternate bite applesauce/pudding/ Interview on 6/10/25 disabilities profession #4's NA is current. F QIDP confirmed clier	on, record review, and failed to ensure food was sistent with the for 1 of 6 audit clients (#4). in the home on 6/10/24 at as observed eating breakfast atmeal, scrambled eggs, x, water and a bowl of oled eggs and peaches were , with client #4 eating all in f client 4#'s nutritional ted 4/15/25 revealed a diet uree diet, regular calorie es/liquids, meds crushed in	W 474	W474 The qualified professional will in-service all staff on diet consistencies for People Supp The clinical team will monitor meal time assessments 1x a v a period of 30 days and then or routine basis to ensure all diet consistence's are followed as prescribed. In the future, the of professional will ensure all stat trained on diet consistencies of People Supported.	ported. through week for on a t qualified aff are	8/9/25
FORM CMS-256	7(02-99) Previous Versions Ob	solete Event ID: RUF	-oil Fa	acility ID: 922107 If c	ondinuation she	et Page 21 of 21