STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G015	A. BUILDING _____ B. WING _____	11/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RUN/ROBIN'S NEST GROUP HOME	3845 ROBIN'S NEST ROAD 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 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 observations, record review and interview, the facility failed to ensure privacy during medication administration and the care of personal needs. This affected for 5 of 6 audit clients (#4, #8, #10, #11, #12). The findings are: 1. Clients were not afforded privacy during medication administration. During observations in the home on 11/4/19 from 5:15pm to 6:00pm, Staff A was observed to give clients #4, #8, #11 and #12 their medications in the dining room. During the observation, there was a client and staff in the kitchen adjacent to the dining room assisting with meal preparation and all other clients were sitting in the living room, also adjacent to the dining room, with a third staff watching television. Each time Staff A would give a client their medication, the staff would loudly state to the client the names of the medication, the uses of the medication, and the side effects of each medication. All other clients were within close proximity to hear the names, uses and side effects of the medications given for clients #4, #8, #11 and #12. Review 11/5/19 of the facilities Medication Administration Policy, revised October 2018, revealed "medications shall be administered in areas that allow for privacy and to minimize distractions."	W 130		

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

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W 130	Continued From page 1 Interview on 11/5/19 with the facility nurse revealed that medications should be given in an area that allows the client privacy while taking his medications. 2. Clients #8 and #10 were not afforded privacy while in the bathroom. a. During observations in the home on 11/4/19 at 4:13pm, client #10 was in the bathroom toileting. Staff C walked into the bathroom without knocking on the door. Interview on 11/5/19 with the home manager revealed that staff should always knock on bedroom and bathroom doors before entering. Interview on 11/5/19 with the qualified intellectual disabilities professional (QIDP) revealed that staff should always knock before entering bedrooms and bathrooms whether the doors are closed or not. b. During observations in the home on 11/5/19 at 6:28am, client #8 was in the bathroom taking a shower. Staff B walked into the bathroom without knocking on the door. Interview on 11/5/19 with the home manager revealed that staff should always knock on bathroom doors before entering. The home manager confirmed that even if a client is in the shower with the water running and may not hear the staff not knock, the expectation is staff should still knock on the door before entering. Interview on 11/5/19 with the QIDP revealed that staff should always knock before entering	W 130		

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W 130	Continued From page 2 bedrooms and bathrooms whether the doors are closed or not.	W 130		
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure clients were afforded opportunities for individual choice-making. This affected 1 of 6 audit clients (#1). The finding is: Client #1's personal leisure choice was not acknowledged. During observations in the home on 11/4/19 from 5:00pm until 6:00pm, client #1 was observed sitting in the living room with four of his peers and Staff C. The television was on the program Sanford and Son. At 5:13pm, client #1 verbalized that he wanted to watch something different. Staff C told him they were watching Fred. At 5:19pm, client #1 went to go take his medications. When he returned at 5:29pm, he again asked to watch something else. Staff C told him to "Watch Fred." At 5:46pm, client #1 asked again to watch something else on TV and Staff C told him, "No, I want to watch Fred." At no point during the observation did the other clients in the living room appear to show interest in watching the television. Review on 11/5/19 of client #1's IPP, dated 8/22/19, revealed that client #1 verbally communicates his wants, needs and emotions.	W 247		

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W 247	Continued From page 3 Interview on 11/5/19 with the home manager revealed that the clients should watch what they want on the television, not what staff want to watch. The home manager stated it's their house and their TV, they should get to chose. Interview on 11/5/19 with the qualified intellectual disabilities professional (QIDP) revealed that client #1 should have been able to watch what he wanted on TV, especially if the other clients did not show any interest in what was on.	W 247		
W 368	DRUG ADMINISTRATION CFR(s): 483.460(k)(1) The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure the system of administrating medications as ordered was implemented. This affected 1 of 6 audit clients (#8) The finding is: Client #8 did not receive his Fluticasone nasal spray as ordered. During morning observations in the home on 11/5/19 at 6:42am, Staff B administered client #8 his Fluticasone nasal spray. Additional observations revealed Staff B placing the nasal spray in each of client #8's nostril and spraying once. Further observations revealed Staff B did not shake the bottle prior to placing into client #8's nostrils.	W 368		

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W 368	Continued From page 4 Review on 11/5/19 of client #8's physician orders signed 10/28/19 stated, "Instill 2 Sprays in each nostril...*Shake Well*." During an interview on 11/5/19, the facility's nurse revealed staff should have followed the physician orders for client #8's nasal spray.	W 368		
W 374	DRUG ADMINISTRATION CFR(s): 483.460(k)(7) The system for drug administration must assure that drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with State law. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure all drugs were packaged and labeled with the name of the person prescribed the medication, with instructions on how to administer the medication and instructions as to how often to administer the medication for 1 of 6 audit clients (#8). The finding is: Client #8's label for his ear drops was faded. During morning medication administration in the home on 11/5/19 at 7:44am, client #8's label for his ear drops was faded and information was unable to be read. During an interview on 11/5/19, the home manager (HM) confirmed the label for client #8's ear drops was faded and the information was unable to be read.	W 374		

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W 374	Continued From page 5 During an interview on 11/5/19, the facility's nurse confirmed the label for client #8's ear drops needs to be replaced seeing it has faded.	W 374		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the potential for cross-contamination was prevented. This potentially affected all clients residing in the home. The findings are: Precautions were not taken to prevent possible cross-contamination during meal preparation tasks. a. During observations in the home on 11/4/19 at 5:11pm, client #12 was in the kitchen emptying the dishwasher. At 5:15pm, Staff B asked client #12 if wanted to assist with stirring the fried apples. Client #12 did not wash his hands and was not prompted to wash his hands. At 5:18pm, client #12 was standing in the kitchen holding a dish towel to his mouth. Throughout the observations during meal preparation, client #12 used the dish towel to wipe his mouth, wipe his nose and wipe the sweat off his face. At 5:43pm, Staff B used the dish towel to dry the pots and pans that were washed. At 5:58pm, Staff B used the dish towel to get the pan of biscuits out of the oven. At 6:11pm, Staff B got a spoon out of the drawer, rinsed it off and used the dish towel to dry it before stirring the chicken and noodles sitting	W 454		

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W 454	Continued From page 6 on the stove. At 6:15pm, Staff B asked client #12 to help him wash and dry dishes. Staff B washed dishes and client #12 dried them off using the dish towel. Interview on 11/4/19 with Staff B revealed that client #12 should not have been allowed to use the dish towel to wipe and clean his face. Further interview revealed that a new dish towel should have been used during meal preparation after the first time client #12 touched the dish towel to his mouth and face. Interview on 11/5/19 with the qualified intellectual disabilities professional (QIDP) revealed that the dish towels should have been changed for a different one. b. During observations on 11/4/19 at 5:55pm, Staff B was observed to touch several surfaces in the kitchen including opening drawers and cabinets, picking up a pot on the stove with chicken in it and putting it in the sink, and throwing some plastic away in the trash can. Staff B was then observed to stand at the sink and de-bone the chicken using his bare hands. Staff B did not wash his hands after touching the various surfaces and before touching the chicken. Additional observations in the home on 11/5/19 at 7:09am revealed Staff D and client #8 wash their hands to begin meal preparation. After washing their hands, client #8 began touching multiple surfaces in the kitchen including walls, counters, canisters, openings drawers and cabinets and touching objects inside and touching the surface of the refrigerator and washing machine. Staff D and client #8 used their bare hands to pick up raw bacon and put it on a plate to cook in the	W 454		

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W 454	Continued From page 7 microwave. At no time was client #8 prompted to re-wash his hands. At 7:09am, client #12 came into the kitchen and started picking up bread with his bare head to put in the toaster. When two pieces were done, he would remove it and put two more pieces in. At no time was client #12 prompted to wash his hands. At 7:26am, Staff D prompted client #8 to wash his hands so they scramble the eggs. At 7:28am, Staff D and client #8 were standing at the stove stirring the eggs and client #8 sneezed two times over the stove. They continued cooking the eggs and the eggs were served for breakfast. Interview on 11/5/19 with the QIDP revealed that staff and clients should wash their hands before beginning meal preparation and should wash their hands again any time they touch any surface. Additional interview revealed that the facility does not have a policy or rule for what to do when touching raw meats, but the expectation is that hands should be washed and cleaned before touching raw meats.	W 454		