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 _____	06/28/2022

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 and interviews, the facility failed to ensure privacy for 3 of 12 audit clients (#3, #7 and #9) residing in the home. The finding is: During morning observations in the home on 6/27/22 at 10:28am, client #7 was observed sitting on the toilet with the door wide open. Further observations at 11:15am, client #3 was observed sitting on the toilet with the door wide open. Client #9 was observed sitting on the toilet at 11:30am with the door wide open. At 4:06pm, client #7 entered the bathroom and sat down on the toilet; the door remained open. Client #9 was observed sitting on the toilet at 4:16pm with the door wide open. Further observations revealed client #9 at 4:31pm and again at 5:35pm sitting on the toilet with the door open. At no time where clients #3, #7 and #9 were given any type of prompts to shut the bathroom door for their privacy. Review on 6/28/22 of client #3's Adaptive Behavior Inventory (ABI) dated 8/21/21 reveals she has no independence to shut the bathroom door for privacy. Review on 6/28/22 of client #7's ABI dated 1/20/22 reveals she has no independence to shut the bathroom door for privacy. Review on 6/28/22 of client #9's ABI dated 1/19/22 reveals she is totally independent with	W 130	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider or the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. Staff will be in-serviced on client's right and the need to ensure privacy during treatment and care of personal needs. Staff will be in-serviced to work with individuals informally to knock before entering a bathroom and to close the door while using the bathroom. Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the Interaction assessment. RECEIVED JUL 11 2022 DHSR-MH Licensure Sect	8.15.2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 7.7.2022

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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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	Continued From page 1 shutting the bathroom door for privacy. During an interview on 6/28/22, the qualified intellectual disabilities professional (QIDP) stated clients #3, #7 and #9 should have been given verbal prompts to shut the bathroom door for privacy.	W 130		
W 242	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(iii) The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on observations, record review and interview the interdisciplinary team failed to assure objective training to meet identified needs relative to dressing were implemented for 1 of 12 audit clients (#7). The finding is: During morning observations in the home on 6/28/22 at 10:34am, client #7 exited the bathroom and walked into the hallway. Further observations revealed client #7 was standing in the hallway with her pants and underwear pulled down to her knees. Client #7 pulled up her pants and underwear, but her buttocks were visible as she walked out the door, onto the back porch. At 3:24pm, client #7 stood up and her pants were low on her hips. Further observations revealed client #7 buttocks were visible to anyone in the home. From 3:56pm until 4:06pm, client #7 was	W 242	Will in-service staff on redirecting and assisting person with clothing being appropriately worn Hab. Spec. will write an objective to work with the individual to become more independent with pulling up pants appropriately. Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the Interaction assessment.	8.15.2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 242	Continued From page 2 sitting in a chair located at the dining room table, Additional observations revealed client #7 buttocks were visible to anyone in the home while she was sitting in the chair. Staff made several verbal prompts for client #7 to pull up her pants, but she did not follow through. Review on 6/28/22 of client #7's Individual Program Plan (IPP) dated 1/19/21 revealed there was not any objective training considered for client #7 to assist her to be more independent in this area. During an interview on 6/28/22, the Qualified Intellectual Disabilities Professional (QIDP) stated staff need to give client #7 verbal prompts to pull up her pants. Further interview revealed client #7 at this times does not have a goal to address to pulling up her pants.	W 242		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 3 of 12 audit clients (#3, #7 and #9) received a continuous active treatment program consisting	W 249	Will train staff on the importance of reminding/prompting person to wash hands. Hab. Spec./ QP to review ABI to ensure strengths and needs are accurate to the individuals.	8.15.2022

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W 249	Continued From page 3 of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of personal hygiene. The findings are: A. During morning observations in the home on 6/27/22 at 10:28am, client #7 was observed sitting on the toilet. Further observations at 11:15am, client #3 was observed sitting on the toilet. Client #9 was observed sitting on the toilet at 11:30am. At 4:06pm, client #7 entered the bathroom and sat down on the toilet. Client #9 was observed sitting on the toilet at 4:16pm. Further observations revealed client #9 at 4:31 and again at 5:35pm sitting on the toilet. At no time where clients #3, #7 and #9 were given any type of prompts to wash their hands after using the toilet. Review on 6/27/22 of client #3's Adaptive Behavior Inventory (ABI) dated 3/10/22 indicated she is not independent with washing her hands after toileting. Review on 6/27/22 of client #7's ABI dated 1/20/22 indicated she has partial independence with washing her hands after toileting. Review on 6/27/22 of client #9's ABI dated 1/19/22 indicated she has total independence with washing her hands after toileting. During an interview on 6/28/22, the QIDP stated clients #3, #7 and #9 should have been given verbal prompts to wash their hands after toileting. B. During morning observations in the home on 6/27/22 at 10:28am, client #7 was observed sitting on the toilet; when she stood up she did not wipe herself, she just pulled up her underwear	W 249	HS to write objectives for handwashing if strength indicated Hab. spec. to write objective for person to follow steps of personal hygiene and wiping after using the restroom if strength indicated. Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the Interaction assessment.	8.15.2022

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W 249	Continued From page 4 and pants and exited the bathroom. Further observations at 11:15am, client #3 was observed sitting on the toilet; client #3 did not wipe herself before exiting the bathroom. Client #9 was observed sitting on the toilet at 11:30am; she did not wipe herself before she left the bathroom. At 4:06pm, client #7 entered the bathroom and sat down on the toilet; she did not wipe herself before she exited the bathroom. Client #9 was observed sitting on the toilet at 4:16pm. Further observations revealed client #9 at 4:31 and again at 5:35pm sitting on the toilet; she did not wipe herself prior to leaving the bathroom. At no time where clients #3, #7 and #9 were given any type of prompts to wipe themselves after using the toilet. Review on 6/27/22 of client #3's Adaptive Behavior Inventory (ABI) dated 3/10/22 indicated she has partial independence with wiping herself after toileting. Review on 6/27/22 of client #7's ABI dated 1/20/22 indicated she has partial independence with wiping herself after toileting. Review on 6/27/22 of client #9's ABI dated 1/19/22 indicated she has total independence with wiping herself after toileting. During an interview on 6/28/22, the QIDP indicated clients #3 and #7 need verbal prompts to wipe themselves after toileting. Further interview revealed client #9 is independent with wiping herself after toileting and she would need a reminder.	W 249		
W 260	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(2)	W 260		

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W 260	Continued From page 5 At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to update the Individual Program Plan (IPP) annually for 1 of 12 audit clients (#7). The finding is: Review on 6/27/22 of client #7's record revealed an IPP dated 1/19/21. Additional review of client #7's record revealed no updated IPP since 1/19/21. During an interview on 6/28/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #7's IPP has been updated.	W 260	QP will conduct annual plan update and ensure all plans are updated at least annually Informal monitoring to occur through monthly chart check observations by Program Manager. Formal monitoring to occur through completion of the ICF Chart Review and the ICF Medical Chart Review conducted twice a year.	8.15.2022
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure staff were sufficiently trained regarding the appropriate disposable of medication and the use of face masks for the prevention of Covid-19. This potentially affected all clients residing in the home (#1, #2, #3, #4, #5, #6 #7 #8, #9 #10, #11, and #12). The findings are: A. During morning medication administration on	W 340	Staff will be trained on the appropriate disposal of medications and on wearing PPE appropriately per facility protocol Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the Interaction assessment.	8.15.2022

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W 340	Continued From page 6 6/28/22 at 7:34am, a client picked up a medication cup with a pill in it and threw the cup and the pill into the trash can. Further observations revealed Staff E punching out another of the same pill from the bubble pack and into another medication cup. During an immediate interview, Staff E stated the pill will remain in the trash can and nothing else needs to be done. During an interview on 6/28/22, the facility's nurse revealed the pill should not have been thrown away in the trash; instead the pill should have been placed in RX Destroyer and then the nurse should have been notified. During an interview on 6/28/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed the pill should not have been left in the trash can. Additional interview revealed there should have been documentation on how the pill ended up in the trash can and then the nurse should have been notified. B. During arrival observation at the home on 6/27/22 at 11:00am, Staff D answered the front door of the home wearing no face mask. Staff D then walked to the dining room area to assist with table activities and engage with clients #1, #4, #8, #10, #11, and #12 wearing no face mask. At 11:05am, the Qualified Intellectual Disabilities Professional (QIDP) entered the home and spoke with Staff D. Staff D was observed wearing a face mask at 11:06am. C. During observations at the home on 6/27/22 from approximately 3:30pm to 6:30pm, Staff B	W 340		

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W 340	Continued From page 7 was observed having his mask below his nose. From 3:30pm to 4:00pm, Staff B wore his mask below his nose while he engaged with clients #4 and #10 in table activities. From 4:00pm to 5:00pm, Staff B wore his mask below his nose while he prepared dinner with client #4. From 5:00pm to 6:00pm, Staff B wore his mask below his nose while in the dining and kitchen area during the entire evening meal. D. During observations at the home on 6/27/22 from approximately 3:30pm to 6:30pm, Staff E was observed having his mask below his chin, revealing his nose and mouth. From 3:30pm to 4:00pm, Staff E wore his mask under his chin as he engaged with client #1, #11, and #8 during table activities. From 4:00pm to 5:00pm, Staff E wore his mask under his chin as he sat with client #1, #8, #10, #11, and #12 in the den. From 5:00pm to 6:30pm, Staff E wore his mask under his chin as he assisted with dining and den recreation. Review on 6/27/22 of posted Covid-19 mask policy revealed that all persons entering facility premises are required to wear a surgical mask. Interview on 6/28/22 with the QIDP revealed that staff should be wearing masks correctly and have been trained repeatedly on wearing masks. When asked if staff should have been worn masks to cover nose and mouth, the QIDP confirmed that this was how staff were trained to wear masks.	W 340		
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed	W 436		

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W 436	Continued From page 8 choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure recommended equipment, specifically eyeglasses, were furnished for 1 of 12 audit clients (#2). The finding is: During observations in the home on 6/27 - 28/22, client #2 was not observed wearing her eyeglasses. Further observations revealed at no time was client #2 prompted to wear her eyeglasses. Review on 6/27/22 of client #2's Individual Program Plan (IPP) dated 4/13/22 stated, "It is important to [client #2] that she wear her glasses during her waking day". Review on 6/27/22 of client #2's visual examination dated 5/18/21 revealed she has a primary diagnosis of Hyperopia. During an interview on 6/28/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #2 should have been wearing her eyeglasses during her awake hours.	W 436	Hab Spec to write an objective for the individual to ensure she is wearing her glasses. Will in-service staff on objective and documentation when she refuses. Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the Interaction assessment.	8.15.2022
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1) and under varied conditions to- This STANDARD is not met as evidenced by: Based on review of fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times.	W 441		

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W 441	Continued From page 9 This affected all clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, and #12) residing in the two homes. The findings are: Review on 6/27/22 revealed eight fire drills were conducted on second shift at: 3:15pm, 3:15pm, 3:10pm, 3:15pm, 4pm, 3:50pm and 3:20pm. During an interview on 6/28/22, the Home Manager (HM) stated she never knew fire drills had to be conducted at varied times. During an interview on 6/28/22, the Direct Support Manger (DSM) revealed fire drills need to be alternated throughout the shift. During an interview on 6/28/22, the Qualified Intellectual Disabilities Professional (QIDP) stated second shift hours are 2:45pm until 10:45pm.	W 441	Group Home manager in-serviced on varying times in conducting facility fire drills. Formal monitoring to occur at least monthly during CQI meetings.	8.15.2022
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infections and prevent possible cross-contamination. This potentially affected 6 of 12 clients (#2, #3, #5, #6, #7 and #9). The finding is: During breakfast observations in the home on 6/28/22 at 8:00am, client #3 picked up a slice of toast and placed it on client #7's plate. A staff person picked up the slice of toast and place it on	W 455	Will In-service staff on cross contamination and what to do if people touch other people's food. Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the Meal time assessment.	8.15.2022

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W 455	Continued From page 10 a serving plate. At 8:02am, client #3 picked up the same slice of toast and placed it on client #5's plate. A staff person then cut up the slice of toast and at 8:03am, client #5 consumed the slice of toast. During an interview on 6/28/22, the Home Manager (HM) stated client #5 should not have been allowed to consume the slice of toast. During an interview on 6/28/22, the Qualified Intellectual Disabilites Professional (QIDP) revealed the slice of toast should have been taken away from client #5.	W 455		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a modfiied and specially prescribed diet consisting of double portions and additional supplements. This affected 1 of 12 audit clients (#10). The findings are: During lunch observations on 6/27/22, client #10 consumed a regular, whole meal consisting of pork loin, mashed potatoes, and collards. Client #10 was served a single portion with no prompting to obtain seconds or a double portion. At no time was client #10 offered a Plus 1 supplement.	W 460	Staff will be in-service to read and follow the individuals' diet as indicated on the meal cards. QP, Group Home Manager and/or HS will ensure all recommended drinks/supplements are in the home and available. Informal monitoring to occur through daily observations by QP, Group Home Manager and/or HS. Formal monitoring to occur through Meal Time Assessments completed monthly by QP, Group Home Manager, and/or HS.	8.15.2022

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FOX RUN/ROBIN'S NEST GROUP HOME	3845 ROBIN'S NEST ROAD LA GRANGE, NC 28551

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W 460	Continued From page 11 During dinner observations on 6/27/22, client #10 consumed a regular, whole meal consisting of salmon, rice, spinach, and rolls. Client #10 was served a single portion with no prompting to obtain seconds or a double portion. At no time was client #10 offered a Plus 1 supplement. During breakfast observations on 6/28/22, client #10 consumed a regular, whole meal consisting of one sausage patty, oatmeal, eggs, and five french toast sticks. Client #10 was served the same portion as all other clients with no prompting to obtain seconds or a double portion. At no time was client #10 offered a Plus 1 supplement. Review on 6/27/22 of client #10's Individual Program Plan (IPP), dated 10/1/21, revealed client #10's prescribed diet to be a whole, regular diet with double portions and a Plus 1 supplement at breakfast and supper, three times daily between meals for snacks. Review on 6/28/22 of client #10's nutritional evaluation, dated 8/12/21, revealed client #10's current prescribed diet to be 1800 calories with double portions and Plus 1 can supplement to be given at breakfast and supper, three times daily between meals. Further review of the nutrion evaluation revealed that client #10's weight should be monitored closely as staff "make sure he is receiving his additional supplement between meals and every day at breakfast and supper, and he is accepting it". Review on 6/28/22 of the home dining guide, located in the home meal preparation book, revealed that client #10 should receive double portions at lunch and dinner. Further review of the	W 460		

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 _____	06/28/2022

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 460	Continued From page 12 home dining guide book revealed client #10 should receive double portions at breakfast, lunch, and dinner, with Plus 1 supplements at breakfast and dinner and as needed for snacks. Interview on 6/28/22 with Staff C revealed that client #10 gets double at breakfast and lunch, but doesn't usually eat it. Staff C stated that when client #10 was hungry, he would eat. Interview on 6/28/22 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that client #10 should get double portions. When asked if staff should prompt him to obtain an extra portion, the QIDP stated that staff should provide or prompt for double portion. When asked if he also received a Plus 1 supplement, the QIDP stated that she was unsure, but she would find out. The QIDP then called the home and spoke with Staff C. The QIDP stated that Staff C confirmed client #10 had received supplements in the past, but there were no supplements in the home. When asked who was responsible for securing the supplements for the home, the QIDP stated that Staff C stated "the nurse usually brings them from the kitchen". When asked if the nurse was responsible for ensuring client #10 received his Plus 1, the QIDP stated that she was not sure. Interview on 6/28/22 with the nurse revealed that the nursing department does not furnish supplements. The nurse stated that the home manager or QIDP is responsible for contacting the kitchen to secure all dietary needs on a weekly basis. The nurse then stated that staff should be ensuring double portions for client #10.	W 460		
W 484	DINING AREAS AND SERVICE	W 484		

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 _____	06/28/2022

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

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W 484	Continued From page 13 CFR(s): 483.480(d)(3) The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to provide recommended adaptive dining equipment. This affected 2 of 12 audit clients (#2 and #7). The finding is: During lunch observations in the home on 6/27/22 at 12:15pm, neither clients #2 and #7 used their portion control plates. Review on 6/27/22 of client #2's IPP dated 4/13/22 stated, "She uses a control plate to assist with controlling portion sizes". Review on 6/28/22 of client #7's nursing evaluation dated 10/7/21 stated, "Adaptive Equipment: Portion control plate... ". During an interview on 6/28/22, the Home Manager (HM) revealed clients #2 and #7 should use their portion control plates at each meal. During an interview on 6/28/22, the Occupational Therapist (OT) revealed client #7 should use her portion control plate at each meal. During an interview on 6/28/22, the Qualified Intellectual Disabilities Professional (QIDP) stated client #2 should use her portion control plate at each meal.	W 484	Staff will be in-serviced on individuals adaptive equipment for meal times (portion control plate) Formal monitoring to consist of QP and Nursing conducting quarterly reviews to include reviewing all Therapist, doctors and specialist recommendation for diets, equipment and protocols and ensure recommendations/diagnosis are consistent and up to date. ICF record review for Non-medical and medical to be completed on the individuals every 6 months.	8.15.2022

RHA
HEALTH SERVICES, LLC

July 7, 2022

Eugina Barnes
Mental Health Licensure and
Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms. Barnes,

Enclosed is the Plan of Correction for the deficiencies noted during the re-certification survey completed on June 28, 2022 for Fox Run and Robin's Nest.

Please feel free to contact me with any questions or concerns. We look forward to seeing you soon for the follow-up.

Respectfully,

Tara Nicki Ethridge TE

Tara "Nicki" Ethridge, RN
Administrator