STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G142	A. BUILDING ______ B. WING ______	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL ROOST GROUP HOME, (ICF/MR)	**102 QUAIL ROOST DRIVE CARRBORO, NC 27510**

(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
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles.	E 037		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 037	Continued From page 1 (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness	E 037		

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E 037	Continued From page 2 policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.	E 037		

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E 037	Continued From page 3 (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 4 *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure new staff received emergency preparedness (EP) plan training upon hire. This had the potential to effect 6 of 6 clients residing in the home (#1, #2, #3, #4, #5 and #6). The finding is: Record review on 3/19/24 of the facility's EP plan training dated 1/18/24 revealed there was no evidence of any of the staff working during the survey receiving their initial EP plan training. Interview on 3/19/24 with the supervisor revealed that she had new staff in the home with some having less than 60 days experience. The supervisor confirmed she was responsible for training the staff on the EP plan but " I did not get around to it yet." Interview on 3/19/24 with the director revealed new hires should be trained on the EP plan within the first 30 days of hire.	E 037		
W 153	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2) The facility must ensure that all allegations of	W 153		

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W 153	Continued From page 5 mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure staff make an immediate report to management of injuries of unknown origin to start an investigation. This effected 1 of 5 audit clients (#6). The finding is: Based on observations throughout the survey 3/18/24 and 3/19/24 revealed client #6 had verbal skills and could made her needs known to staff. Client #6 walked quickly but had a steady gait. Client #6 wore long pants and her skin condition was unknown. Record review on 3/18/24 of a log documenting an event from 3/16/24 at 9:44am revealed Staff J recorded she found light colored bruises on the front and side of the thighs of client #6. Staff J recorded that she concluded "these are might likely the results of her bumping into objects when walking too close to them." There were no logs that the supervisor, nurse or director were notified of client #6's new injuries. Interview on 3/19/24 with the supervisor revealed she was not notified of client #6's bruises and only learned of the incident today. The supervisor revealed client #6 had a history of bumping into things and had seizures and it was possible her injuries were the result of this. The supervisor further added she was off over the weekend (3/16/24), and she felt certain the nurse probably reviewed the log but acknowledged there was no record the nurse was aware.	W 153		

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W 153	Continued From page 6 Interview on 3/19/24 with the director revealed client #6 typically bumped into objects. The director acknowledged staff were expected to report new injuries to the supervisor and create a general record event (GRE). The supervisor and the nurse were supposed to review the GRE and follow up on the cause of the injury.	W 153		
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 review and interview, the facility failed to ensure 2 of 5 audit clients (#2 and #3) received a continuous active treatment program consisting of needed interventions and services regarding the use of adaptive equipment use. The findings are: A. Observation in the home on 3/18/24 at 6:45pm, revealed Staff F served client #2's meal on a regular plate. An additional observation on 3/19/24 at 8:35am revealed Staff H served client #2's meal on a regular plate. While supervising the meal, Staff F was observed to assist client #2 load food on her weighted spoon, since there was no divider in the plate to help her scoop.	W 249		

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W 249	Continued From page 7 Record review on 3/18/24 of client #2's IPP revealed she should use a divided lipped plate at meals. Interview on 3/19/24 with Staff H revealed client #2 only used the divided plate at her day program. Interview on 3/19/24 with the supervisor revealed client #2 should use a divided lipped plate at all meals and at home too. Interview on 3/19/24 with the director revealed the adaptive equipments purpose was to assist clients with independence and the divider in the plate was used to help scoop. B. Observation in the home during the medication pass on 3/18/24 at 5:20pm Staff C poured water into a plastic drinking cup and allowed client #3 to drink the water after ingesting her medications. Staff C placed the cup in client #3 hands and instructed her to drink the water. Staff C did not offer client #3 her sippy cup for drinking. Review on 3/18/24 of client #3 individual support plan dated 2/16/23 revealed adaptive equipment a cup with round mouth piece. Interview on 3/19/24 with Staff C confirmed client #3 does use a sippy cup for drinking. Staff C revealed she was not told to use the sippy cup during the medication pass. Interview on 3/19/24 with the director confirmed client #3 does use a sippy cup for drinking and should use when drinking at anytime including medication pass.	W 249		

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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 interview, nursing services failed to ensure staff were sufficiently trained in the administering of the medications. This affected 2 of 5 audited clients (#3 and #6). The finding is: During 2 of 2 medication pass observations in the home on 3/18-19/24, Staff C prepared client #3's medications into a medication cup prior to client #3 presences in the medication room. After Staff C prepared the medications she called client #3 to the medication room and administered the medications. Staff C also prepared #6's medications prior to client #6 entering the medication room. Staff C called client #6 to the medication room and administered the medications. Interview on 3/19/24 with Staff C revealed that she prepares client #3 and client #6 medication before they enter the medication room due to them being impatient and not wanting to sit while the medications are being prepared with them present. Interview on 3/19/24 with the home supervisor revealed they have always passed medications to client #3 and client #6 by preparing them while they are not present.	W 340		
W 368	DRUG ADMINISTRATION	W 368		

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W 368	Continued From page 9 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 observations, record reviews and interviews, the facility failed to ensure physician's orders were being followed. This affected 1 of 5 audit clients (#5). The finding is: Observation on 3/19/24 at 7:40am medication pass. Client #5 was not administered Polyethylene glycol powder, medication was not present in the facility. Review on 3/19/24 of client #5's physician's orders dated 10/17/23 revealed the following order: Polyethylene glycol powder, mix 8.5 gm in a suitable liquid and drink by mouth everyday in the morning. Further review of client #5's medication administration record indicated medication was missed on 3/18/24 and 3/19/24 medication unavailable. Interview on 3/19/24 the nurse indicated she was unaware of a medication not being present in the home or client #5 missing any medication for two days 3/18-19/24. The nurse also indicated that the physician should be notified when more than 1 dose of medicaiton is missed.	W 368		
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 record review and interview, the facility failed to ensure fire drills were conducted at	W 441		

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W 441	Continued From page 10 varying times and conditions. This had the potential to effect 6 of 6 clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: Record review on 3/18/24 of the fire drills revealed 8 out of 9 drills over a year period were all conducted during the evening. There were no drills conducted during the morning or deep sleep hours, despite suggested hours listed on the Fire/Disaster Drills Summary Sheet. 4/9/24 at 8:53pm 5/15/23 at 4:55pm 7/10/23 at 6:55pm 10/26/23 at 7:12pm 1/24/24 at 5:05pm 2/15/24 at 6:30pm 2/21/24 at 9:38pm 3/7/24 at 6:19pm Interview on 3/19/24 with the supervisor revealed she acknowledged that she had not gotten around to train the newest staff how to do fire drills. The supervisor also acknowledged, she reviewed the monthly fire drills but had not noticed they were not following the suggested times on the schedule. Interview on 3/19/24 with the safety coordinator revealed their safety committee created the drills schedule for staff to follow. They have two shifts, the night shift beginning at 9:00pm. The safety director revealed there were no morning drills because the clients attended a day program during those hours.	W 441		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1)	W 460		

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W 460	Continued From page 11 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 observation, record review and interview, the facility failed to ensure 1 of 5 audit clients (#2) received a modified diet as prescribed. The finding is: During dinner observations in the home on 3/18/24 at 6:45pm, client #2 was observed supervised at the table with Staff F supervising the meal. On the plate, client #2 received sliced corn beef brisket, cooked cabbage, boiled potato, a large biscuit and sliced canned peaches. None of her food was cut into 1/4" pieces. Client #2 was observed to eat the meal without difficulty but required repeated prompts to slow down her pace of eating. An additonal observation on 3/19/24 of breakfast in the home at 8:40am, client #2 was given a plate of food to eat by Staff H who prepared it. On the plate there was a whole English muffin that appeared spongy, not toasted, cooked oatmeal, mixed berries fruit and a hard boiled egg, cut into chunky pieces. Staff F supervised client #2 at her meal and prompted her to slow down and take sips during the meal. Client #2 showed no difficulty eating breakfast. Record review on 3/18/24 of client #2's individual program plan (IPP) from 10/26/23 revealed she was on a regular diet of 1/4" pieces. The ISP revealed client #2 sometimes had difficulty taking small bites, and putting too much food in her mouth, where she would swallow without chewing	W 460		

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W 460	Continued From page 12 the food, plus not eat a safe pace. Interview on 3/19/24 with Staff H revealed boiled egg was a soft food that client #2 could chew and she needed the English muffin cut into 4 pieces. Interview on 3/19/24 with the supervisor revealed client #2 needed her food cut into bite-sized pieces. The supervisor acknowledged she did have a visual guide food texture board that staff could refer to prepare modified meals. Interview on 3/19/24 with the director revealed the supervisor was responsible for training staff how to prepare modified meals.	W 460		