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 ______	06/27/2023

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
E 004	Develop EP Plan, Review and Update Annually CFR(s): 483.475(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(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 §485.625(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 that meets the requirements of this section, utilizing an all-hazards approach. * [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.	E 004	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. The updated emergency contact information was added to the manuals at both group homes on 6.26/2023. This will be monitored and updated annually by the Administrator and the Program Manager.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/5/2023

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 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the emergency preparedness plan (EPP) was reviewed and updated at least every two years. The finding is: Review of the facility EPP manual on 6/26/23 revealed outdated facility contact numbers. Further review of the facility EPP manual revealed no updated community emergency contact information. Interview with the program manager (PM) on 6/27/23 revealed that they had an updated master list but the list was not updated in the home. The PM stated that home EPP manuals should have updated contact information.	E 004		
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 observation, record review and interviews, the facility failed to ensure client #6 had the right to privacy during the care of her personal needs. This affected 1 of 6 audit clients. The finding is: During morning observations in the home on	W 130	Staff will be in-serviced on privacy and providing reminders to individuals when they are using the bathroom, by providing prompts to individuals "Close the door." Informal observations and monitoring will be done weekly by QP and Home Manager.	

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W 130	Continued From page 2 6/27/23 at 6:29am, client #6 was noted in a hall bathroom with the door wide open. The client was naked with the exception of her panties. Client #6 remained unclothed and visible to anyone in the home until 6:31am. During this time, two staff were in other areas of the home. Interview on 6/27/23 with Staff D revealed client #6 can close the door on her own when dressing after her shower. Review on 6/27/23 of client #6's Individual Program Plan (IPP) dated 5/16/23 revealed she closes doors to ensure her privacy and the privacy of others. Interview on 6/27/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 can close the door to ensure her privacy; however, she needs reminders to do so.	W 130		
W 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure client #9 had the right to retain her personal possessions. This affected 1 of 6 audit clients. The finding is: During morning observations in the home on 6/27/23 at 6:37am, Staff C retrieved a small pencil pouch from on top of a tall television stand in the living room, took it into client #9's bedroom and removed a small remote control from the	W 137	Staff will be in-serviced on clients' rights and to ensure that all individuals have access to their personal belongs without any restrictions. Informal monitoring will be done at least weekly by the QP and Home Manager.	

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W 137	Continued From page 3 pouch. The staff proceeded to use the remote to turn on client #9's television and returned the remote to the top of the television stand in the living room. Immediate interview with Staff C revealed the remote belongs to client #9's personal television and is kept on top of the television stand in the living room to keep it from getting lost and due to another client's inappropriate behaviors. The staff indicated client #9 will have a staff retrieve the remote when she wants to use it since she cannot reach it on top of the television stand. Review on 6/27/23 of client #9's Individual Program Plan (IPP) dated 6/21/23 revealed she likes "watching TV in her bedroom." Additional review of the client's Rights Assessment last updated 2/24/23 revealed she requires full support from others to ensure her right to access her personal items is protected. Interview on 6/27/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #9's remote is kept on top of the television stand at the request of her mother so it wouldn't "get misplaced." Additional interview confirmed another client in the home will take items belonging to others and throw them in the trash. The QIDP acknowledged client #9's personal belongings should be kept in her room.	W 137		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.	W 189	Staff will be in-serviced on appropriate areas that are designated for grooming and personal care such as personal room or bathroom. Informal monitoring will be provided by the QP and Home Manager at least weekly.	

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W 189	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to ensure were sufficiently trained to provide personal space, privacy and proper cleaning techniques during/after grooming activities. This affected 1 of 6 audit clients (#2). The finding is: During evening observations in the home on 6/26/23 from 3:27pm - 4:49pm, Staff B removed braids from client #2's hair while combing and brushing through the clients hair. This grooming task was performed as the client sat in between the kitchen and dining room of the home. Throughout this time, client #7 sat approximately a foot away from client #2. Client #7 was also observed to sit in a chair containing hair on the seat. Large clumps of hair were noted on the floor in the area where the client was seated and on the kitchen floor. Upon completion of the grooming task, the staff picked up larger clumps of hair; however, the floor was not swept and the area was not cleaned or sanitized. Interview on 6/26/23 with Staff B revealed she had started removing braids from client #2's hair on yesterday; however, she could not finish it so she decided to remove the remaining braids today. Interview on 6/27/23 with the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff should have completed the grooming task in client #2's bedroom or a bathroom if one was available. The QIDP acknowledged combing hair near the kitchen and dining areas was not appropriate.	W 189		
W 227	INDIVIDUAL PROGRAM PLAN	W 227		

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W 227	Continued From page 5 CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure 1 of 6 audit clients (#4) Individual Program Plan (IPP) included objectives to address his toothbrushing needs. The finding is: Review on 6/27/23 of client #4's IPP, dated 9/14/22, revealed a history of Gingival Disease and adaptive equipment to include an electric toothbrush. No personal care training objectives could be located. However, the IPP revealed client #4 depends on staff to ensure thorough toothbrushing. Staff are to use a timer and electric toothbrush three times per day for two minutes following client #4 attempting to brush his teeth. Informal training is encouraged for client #4 with no formal objective. Review on 6/27/23 of client #4's Adaptive Behavior Inventory (ABA), dated 4/12/23, revealed client #4 to have no independence in brushing teeth thoroughly or cleaning gums with a rating of 1. Interview on 6/27/23 with the Qualified Intellectual Disabilities Professional (QIDP) revealed client #4 does require staff to ensure thoroughness of brushing his teeth. The QIDP stated she thought he had a goal for this area and acknowledged that client #4 should have formal training for toothbrushing skills.	W 227	Habilitation Specialist will create objectives according to the individuals needs according to their Adaptive Behavior Inventory. A tooth brushing objective will be implemented, and the staff will be in-serviced on the objective. Informal monitoring will be provided by the QP at weekly to ensure accuracy.	

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W 249	Continued From page 6	W 249		
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 2 of 6 audit clients (#5 and #6) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the areas of cooking, participation with medication administration, and dining skills. The findings are: A. During observations of cooking tasks at lunch and dinner in the home on 6/26/23, Staff A and Staff B performed necessary tasks to prepare food items such as ham, noodles, broccoli, hamburgers, tater tots, and tossed salad. As client #6 stood in the kitchen during meal preparation, she was only prompted to season the hamburgers, put pudding cups on the table and place eating utensils. Client #6 was not prompted or encouraged to assist with cooking tasks. Interview on 6/27/23 with Staff A revealed client #6 can assist in the kitchen by placing food on	W 249	Staff will be in-serviced on all individuals' Individual Program Plans to ensure they have a clear understanding of active treatment that they are to implement for each individual. Informal weekly monitoring by the QP and Home Manager will b provided.	

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W 249	Continued From page 7	W 249		

pans, stirring, washing dishes, and getting out condiments. Additional interview indicated she does not let the clients get too close to the stove because she is afraid they will get burned.

Review on 6/27/23 of client #6's IPP dated 5/16/23 revealed, "She enjoys cooking." The plan noted she assists with mealtime preparation activities and is "independent with simple meal prep."

Interview on 6/27/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #6 likes to help in the kitchen and can stir items, brown meat in a pan, fill pots with water, place biscuits on a pan, and pre-heat the oven with assistance. The QIDP acknowledged the client likes to help in the kitchen and staff should provide the necessary assistance for her to participate with cooking tasks.

B. During observations of medication administration in the home on 6/27/23 at 7:40am, Staff A retrieved client #6's medications from the cart, named some of the pills, and signed the MAR. Client #6 was noted to punch her pills, retrieve a cup of water, take her pills and throw away trash. The client named one of her pills.

Review on 6/27/23 of client #6's IPP revealed during medication administration she can locate and obtain medications from the cart, obtain pills by pushing them through the pill pack, retrieve drinking cups, take medications, dispose of trash and sign a modified MAR independently. The plan also indicated the client can state the name of medications and reasons for taking them given a verbal cue.

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W 249	Continued From page 8 Interview on 6/27/23 with the QIDP confirmed client #6 should be assisting with medication administration as indicated in her plan. C. During lunch observations in the home on 6/26/23 at 1:08pm, client #6 served herself a single slice of ham and other food items. The ham was approximately the size of the palm of an adult's hand. At the meal, client #6 attempted to cut the ham into smaller pieces using the edge of her spoon. No knives were available at the table. Interview on 6/27/23 with Staff A revealed client #6 can use a knife for cutting. Review on 6/27/23 of client #6's IPP dated 5/16/23 revealed she can independently use a knife for cutting her food. Interview on 6/27/23 with QIDP confirmed client #6 can use a butter knife at meals for cutting. D. During 3 of 3 mealtime observations in the home on 6/26 - 6/27/23, client #5 sat in a chair at the table with her legs crossed over each other. The client was not prompted or assisted to uncross her legs while seated at meals. Review on 6/27/23 of client #5's IPP dated 1/6/23 revealed a foot stool previously used when sitting at the table had been discontinued. The plan noted, "...continue to encourage her to uncross her legs when she is eating." Interview on 6/27/23 with the QIDP confirmed client #5 should be encouraged to uncross her legs while eating.	W 249		
W 255	PROGRAM MONITORING & CHANGE	W 255		

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W 255	Continued From page 9 CFR(s): 483.440(f)(1)(i) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client #5's Individual Program Plan (IPP) was revised after she had successfully completed objectives. This affected 1 of 6 audit clients. The finding is: Review on 6/26/23 of client #5's IPP dated 1/6/23 revealed objectives to put deodorant under her arms with physical prompts 50% of trials for 2 consecutive months, to flush the toilet after using it with physical prompts 50% of trials for 2 consecutive months and an objective to spend 10 minutes doing a leisure activity with physical prompts for 50% of trials for 2 consecutive months. Additional review of progress notes for the objectives revealed the following: Apply deodorant 10/22 - 0% 11/22 - 0% 12/22 - 0% 01/23 - 0% 02/23 - 0% 03/23 - 60% 04/23 - 81% Flush toilet 05/22 - 40%	W 255	The Habilitation Specialist will be in-serviced on the need to review data weekly to monitor individuals progress with objectives. Therefore, implement revisions to the objectives as needed. QP will review objectives and data 1 time per week for 1 month and 2 times per month thereafter.	

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W 255	Continued From page 10 06/22 - 50% 07/22 - 58% 08/22 - 75% 09/22 - 83% Leisure activity 04/22 - 50% 05/22 - 41% 06/22 - 50% 07/22 - 50% Interview on 6/27/23 with the Qualified Intellectual Disablilites Professional (QIDP) confirmed the objectives had been completed; however, training continued.	W 255		
W 257	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(1)(iii) The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is failing to progress toward identified objectives after reasonable efforts have been made. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Individual Program Plan (IPP) for 1 of 6 audit clients (#6) were revised after clients failed to progress towards identified objectives. The findings is: A. Review on 6/26/23 of client #6's IPP dated 5/16/23 revealed objectives to assisting with writing a grocery list 80% of trials for 3 consecutive months, to identify the correct hour with 3 or less verbal cues 80% of trials for 3 consecutive months and to brush her teeth 80%	W 257	The Qualified Professional will be in-serviced on the need to review data monthly to monitor individuals progress with objectives and revise IPP as needed. Program Manager will review objectives and data 1 time per week for 1 month and 1 time per month thereafter.	

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W 257	Continued From page 11 of trials for 3 consecutive months. Additional review of progress notes for the objectives indicated the following: Grocery list 08/22 - 100% 09/22 - 75% 10/22 - 0% 11/22 - 0% 12/22 - 0% 01/23 - 0% 02/23 - 0% 03/23 - 20% 04/23 - 100% Correct hour 08/22 - 66% 09/22 - 58% 10/22 - 0% 11/22 - 0% 12/22 - 0% 01/23 - 0% 02/23 - 0% 03/23 - 0% 04/23 - 0% Brush teeth 08/22 - 75% 09/22 - 66% 10/22 - 0% 11/22 - 0% 12/22 - 0% 01/23 - 0% 02/23 - 0% 03/23 - 10% 04/23 - 25%	W 257		

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W 257	Continued From page 12 Interview on 6/27/23 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed the objectives need to be revised.	W 257		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all medications were administered without error. This affected 1 of 2 clients (#5) observed receiving medications in the Robin's Nest Group Home. The finding is: During observations of medication administration in the home on 6/27/23 at 7:29am, client #5 ingested Certirizine, Levothyroxine, a Multivitamin and Vitamin D3. No other medications were administered at this time. Review on 6/27/23 of client #5's physician's orders dated June 2023 revealed an order for Lactulose 10gm/15ml solution, 30ml by mouth every morning at 8:00am. Interview on 6/27/23 with the facility's nurse confirmed client #5 should have received Lactulose during morning medication administration as ordered.	W 369	The staff will be in serviced on medication administration to that medication is given to the right person, right medication, right dose, right time, right route, and right documentation. The QP and Home manager will informally monitor medication passes 1 per week for 1 month and monthly thereafter.	
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and	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 ______	06/27/2023

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 13 specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 6 clients (#4 and #11) received their specially-prescribed diets as indicated. The finding is: A. During dinner observations on 6/26/23 at 5:10pm, client #4 was served one hamburger with bun, one serving of mashed potatoes, and Kool-Ade as beverage. No double portion was served to client #4. During breakfast observations on 6/27/23 at 8:00am, client #4 was served one biscuit with one serving of sausage gravy, two whole boiled eggs, and juice. No double portion was served to client #4. Review on 6/26/23 of client #4's individual program plan (IPP), dated 9/14/22, revealed a prescribed whole, regular diet for weight gain with a high calorie snack at bedtime. In addition, client #4 should receive double portions at meals, with prune juice at breakfast. Review on 6/27/23 of client #4's nutritional evaluation, dated 9/12/22, revealed a whole, regular diet with a high calorie snack at bedtime. In addition, staff should "Make sure he is receiving double portions at each meal and is accepting it." Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 6/27/23 revealed client #4 was a "picky" eater and would not eat everything. The QIDP stated client #4 should receive double portions on his plate as prescribed by the nutritionist.	W 460	Staff will be in-serviced on diet consistency, portions, limitations, utensils, and level of independence for individuals to ensure meals are served appropriately. Informal monitoring will be done by Home manager and QP on a weekly basis.	

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 ______	06/27/2023

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 460	Continued From page 14 Interview with the Program Manager (PM) on 6/27/23 revealed clients should receive prescribed diets as written. B. Observations on 6/26/23 from 3:30pm-5:00pm revealed no snack was offered to client #11. During dinner observations on 6/26/23 at 5:10pm, client #11 was served one hamburger with cheese and bun, one serving of mashed potatoes, and Kool-Ade as beverage. No double portion was served to client #11. Client #11 was offered and consumed a second serving of mashed potatoes only; no second serving of hamburger was offered. During breakfast observations on 6/27/23 at 8:00am, client #11 was served one biscuit with one serving of sausage gravy, one serving of oatmeal, one serving of scrambled eggs, and juice. No double portion was served to client #11. Client #11 was offered and consumed a second serving of oatmeal and sausage gravy only; no second serving of biscuit or eggs was offered. Review on 6/26/23 of client #11's IPP, dated 4/12/23, revealed a prescribed regular, weight gain diet with 1/2 inch consistency due to choking risk. In addition, client #11 should receive double portions at each meal with the following specific snacks: 10-10:20 Yogurt, peanut butter and crackers 4-4:30pm Pudding and fruit cup 8-8:30pm Peanut butter and jelly sandwich 1 cup milk Review on 6/27/23 of client #11's nutritional evaluation, dated 3/27/23, revealed a prescribed	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 ______	06/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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W 460	Continued From page 15 regular, weight gain diet with 1/2 inch consistency due to choking risk. In addition, client #11 should receive double portions at each meal with the following specific snacks: 10-10:20 Yogurt, peanut butter and crackers 4-4:30pm Pudding and fruit cup 8-8:30pm Peanut butter and jelly sandwich 1 cup milk Interview with the Qualified Intellectual Disabilities Professional (QIDP) on 6/27/23 revealed client #11 could receive seconds. When asked if client #11 should be offered seconds or receive a double portion on his plate, the QIDP stated client #11 should receive double portions as prescribed. The QIDP further stated client #11's prescribed snack schedule should be followed to help hinder his aggressive eating behavior and follow his written plan. Interview with the Program Manager (PM) on 6/27/23 revealed clients should receive prescribed diets as written.	W 460		