STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G286	A. BUILDING _____ B. WING _____	C 03/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE, INC GREY FOX RUN GROUP HOME	**312 GREY FOX RUN NEWPORT, NC 28570**

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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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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.

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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 interviews, the facility failed to ensure all staff were trained on the facility's Emergency Preparedness (EP) plan. The finding is: Review on 3/11/25 of the facility's EP plan training documents did not indicate all new and/or existing staff had received initial training and/or retraining on the EP plan. Interview on 3/11/25 with the Director of ICF Services confirmed staff training on the facilty's EP plan should occur for all new and existing staff within a certain timeframe.	E 037		
W 000	INITIAL COMMENTS A complaint and recertification survey were completed on 3/11/25 for intakes #NC00226533 and #NC00226580. The complaint was substantiated. Deficiencies were cited.	W 000		
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,	W 189		

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efficiently, and competently.
This STANDARD is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure all staff were proficiently trained on the individual program plans (IPP) for 1 of 3 audit clients (#3). The finding is:

On 3/10/25 at 12:35pm, upon entering the home, surveyors were notified by Staff B that client #3 was groping others and had just received an emergency dose of his behavior medication. Staff C was present in the room as well as Staff A who was assigned to provide 1:1 supervision of client #2. Client #3 was observed to touch the name tag of surveyor, and to touch staff on the arm mainly, and was immediately redirected by Staff B and Staff C to allow personal space.

Record review on 3/10/25 revealed client #3's IPP dated 5/28/24 identified he manifested a targeted behavior of invading other's personal space as well as aggression. In addition, on 3/11/25 review of client #3's updated 3/5/25 Behavior Support Plan (BSP) revealed if staff were unsuccessful with directing him to provide personal space, he should be escorted away from others until he is calm (not needing further interventions for 3-5 seconds). If client #3 continued to engage in inappropriate touching, he should be escorted away from the area until he is calm for 5 minutes. Emergency drug use, was available if he failed to calm down.

Review on 3/10/25 of an inservice dated 1/21/25 revealed a training regarding protecting privacy and ensuring clients were monitored. An additional inserviced dated 2/12/25 revealed training regarding staff monitored client #3 to

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prevent him from invading other clients' personal space ; and to physically assisted to back away and to "model space needed." The inservices attendance sheet verified that Staff B and Staff C did not receive the training for client #3's plans.

Interview with Staff C on 3/10/25 revealed her permanent assignment was with another home and she had been helping out for the past week. Staff C revealed she had to intervene today at lunch time when she noticed client #3 invading the personal space of client #4, pulling on his beaded necklaces and tongue. Staff C revealed that client #2 was also in the room, but his 1:1 staff was providing personal care to client #4. Staff C revealed she physically intervened to separate client #3 from client #4 twice. On 3/11/25, Staff C acknowledged to surveyor that she was not familiar with the clients IPPs.

Interview on 3/11/25 with the Program Specialist and Administrator revealed they were not aware of the incident yesterday between client #3 and another client and offered to play the video footage to determine what happened. The Program Specialist acknowledged that on 3/10/25 at 12:04pm, there were three clients left alone in the living room, including client #3. Staff C could be observed working in the kitchen, which faced the living room area. Client #3 was not provoked when he lunged at another client; Staff C responded by separating him twice. Staff A and Staff B were also on duty, and observed to return to the living room after the incident was resolved. The Program Specialist acknowledged that the clients needed to be closely monitored and Staff B and Staff C were less familiar with the clients plans due to being a new hire and a temporary assignment.

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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 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 observation, record review and interviews, the facility failed to ensure client #1 was taught to use his eyeglasses appropriately and make informed choices about their use. This affected 1 of 3 audit clients. The finding is: During observations throughout the survey on 3/10 - 3/11/25, client #1 did not wear eyeglasses. Although he received infrequent verbal prompts to wear his eyeglasses, client #1 continued to refuse them. Interview on 3/11/25 with client #1, when asked where his eyeglasses were kept, he retrieved them from a bedside drawer in his room. When asked when he wears his eyeglasses, the client indicated he does not wear his eyeglasses. Review on 3/11/25 of client #1's eye exam report dated 10/10/24 revealed bilateral astigmatism with a prescription for eyeglasses. Additional review of client #1's Individual Program Plan (IPP) dated 8/12/24 revealed no information regarding his eyeglasses or training to teach him to wear his eyeglasses appropriately and to make informed choices about his eyeglasses. Interview on 3/11/25 with the Director of ICF Services confirmed client #1 does not like to wear his eyeglasses, will get angry when asked to wear	W 436		

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W 436	Continued From page 8 them and is resistive to wearing them. Additional interview confirmed the client has not receive any training regardmg his eyeglasses.	W 436		