

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G142	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/05/2026
NAME OF PROVIDER OR SUPPLIER QUAIL ROOST GROUP HOME, (ICF/MR)			STREET ADDRESS, CITY, STATE, ZIP CODE 102 QUAIL ROOST DRIVE , CARRBORO, North Carolina, 27510	
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W0130	<p>PROTECTION OF CLIENTS RIGHTS</p> <p>CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, record review and interviews, the facility failed to ensure privacy during treatment and care of personal needs for 1 of 4 audit clients (#4). The finding is:</p> <p>Morning observations on 5/5/26 at 7:28am revealed Staff F leaving the medication office with pre-poured medication cups, heading to the bathroom on the hall. Staff F left the bathroom door ajar and was observed giving client #2 her medication.</p> <p>Record review of client #2's Skill Assessment dated 3/3/25 revealed she needed assistance with restroom care.</p> <p>Interview on 5/5/26 with the Home Manager revealed she discusses ensuring bathroom privacy for clients with staff in their monthly meetings.</p> <p>Interview on 5/5/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff are expected to close the door when clients need privacy.</p>	W0130		
W0361	<p>PHARMACY SERVICES</p> <p>CFR(s): 483.460(i)</p> <p>The facility must provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, record review and interviews, the facility failed to obtain medication for 1 of 4</p>	W0361		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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W0361	<p>Continued from page 1 audit clients (#4) from an alternative pharmacy in a timely manner after this medication had been prescribed by a physician. The finding is:</p> <p>During morning medication administration observations in the home on 5/5/26 at 7:25am, Staff F was not observed providing client #4 with Absorbase Ointment to rub on her skin.</p> <p>Record review on 5/5/26 revealed client #4's Physician's Order signed on 3/31/26 prescribed Absorbase Ointment twice a day to affected area.</p> <p>Record review on 5/5/26 of the facility's procedures for Medication Ordering, Receiving and Returning revealed refills are typically requested before 3:00pm from Sunday-Thursday. "A 5-day supply of medications should be available at all times; therefore, medications should be listed for re-order when the supply is down to 7-days to allow up to 48 hours for delivery. Each support professional is responsible for alerting the direct care professional (DCP) or supervisor upon discovering that a medication supply is getting low."</p> <p>Interview on 5/5/26 with Staff F revealed Absorbase Ointment was out of stock and the medication administration record (MAR) documented it was last administered on 5/4/26.</p> <p>Interview on 5/5/26 with the Home Manager (HM) revealed she was aware the Absorbase Ointment ran out and had made phone calls to the pharmacy in advance but did not recall the dates. The HM revealed the pharmacy did not have the medication on hand and had to order it, causing the delay. The HM anticipated the pharmacy would deliver the medication today. The HM acknowledged she was not aware of their procedures to use an alternative pharmacy.</p> <p>Interview on 5/5/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed they could have made a call into another pharmacy if the main pharmacy could not deliver the medication within 48 hours. The QIDP revealed she expected the refill to start 5 days before the medication ran out.</p>	W0361		
W0369	<p>DRUG ADMINISTRATION</p> <p>CFR(s): 483.460(k)(2)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p>	W0369		

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W0369	<p>Continued from page 2 This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#4) did not receive a duplicate dose of medication, resulting in error for 1 of 4 audit clients (#4). The finding is:</p> <p>During morning medication observations in the home on 5/5/26 at 7:24am, Staff F was in the medication room with client #4. Client #4 participated in the administration by removing her medications, in a basket, from the closet and placed on the desk and removed one medication at a time. Client #4 first popped out each pill from the blister pack into a pill cup, ingested and drunk water afterwards. Staff F sat at the desk with the controlled medication on the desk and was trying to open the padlock, not closely observing client #4. Client #4 removed a tube of Metronidazole Topical 0.75%, placing a small dab on the tip of her finger and rubbed it on her lower jaw and chin and then returned the medication to the package. Staff F opened the controlled medication box and then turned her attention to client #4, placing gloves on her hand on the tube of Metronidazole Topical 0.75% and took a dab of medication and rubbed it over client #4's entire face.</p> <p>Interview on 5/5/26 with Staff F confirmed she did not see client #4 apply the ointment on her face this morning, before she re-applied the Metronidazole Topical 0.75%.</p> <p>Interview on 5/5/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 receiving her Metronidazole Topical 0.75% twice for the 8:00am medication administration resulted in an error.</p>	W0369		
W0382	<p>DRUG STORAGE AND RECORDKEEPING</p> <p>CFR(s): 483.460(l)(2)</p> <p>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record reviews and interview, the facility failed to ensure medications remained secured when not in use. This affected 2 of 4 audit clients (#2 and #3). The findings are:</p> <p>A. Evening observations in the home on 5/4/26 at 5:06pm revealed Staff D pre-pulled medications for</p>	W0382		

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W0382	<p>Continued from page 3</p> <p>client #2. Left in a pill cup on the desk were Ondansetron and Omeprazole in applesauce. Staff D walked out of the medication room, leaving the door open, to get client #2 to take her medications; they returned a minute later.</p> <p>Record review on 5/4/26 revealed client #2 had Physician's Orders signed 1/12/26 that prescribed Ondansetron 4mg and Omeprazole 40mg at 5:00pm.</p> <p>B. Evening observations in the home on 5/4/26 at 5:11pm revealed Staff D pre-pulled medications for client #3. The blister packs of medications were left on the table, with the door open to the medication room as Staff D walked to the kitchen to get the client. On the desk were packages of Propranolol, Infant Mylicon Gas Relief and Vit Code Raw Iron. Staff D and Client #3 returned to the room a minute later.</p> <p>Record review on 5/4/26 revealed client #3 had Physician's Orders signed 1/15/26 that prescribed Propranolol 60mg, Infant Mylicon Gas Relief and Vit Code Raw Iron at 5:00pm.</p> <p>Policy Review on 5/5/26 revealed the facility's Clinical Skills Checklist for Medication Administration dated 1/2026, staff must lock medication area when not in use.</p> <p>Interview on 5/5/26 with the Home Manager confirmed medications should be secured.</p>	W0382		
W0391	<p>DRUG LABELING</p> <p>CFR(s): 483.460(m)(2)(ii)</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to ensure staff only administered medications with attached labels containing the physician's instructions for use, dosage and frequency for 1 of 4 audit clients (#3). The finding is:</p> <p>During evening medication administration in the home on 5/4/26 at 5:09pm, Staff D poured 2.4 milliliters (ML) of Infant Mylicon Gas Relief liquid into a pill cup before opening a capsule of Vitamin Code Raw Iron, emptying the contents in a cup with water. Staff D verbally prompted client #3 to drink all of her medication. Observation of the Infantile Mylicon Gas Relief and Vitamin Code Raw Iron confirmed they</p>	W0391		

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W0391	Continued from page 4 were over the counter medications and did not have a pharmacy label, the name of the clients or instructions on how to administer the medication. Record review on 5/5/26 of client #3's Physician's Orders signed 3/31/26 confirmed Mylicon Gas Relief liquid was included, with the client receiving 2.4 ML four times a day. There was also a "literal order" for Raw Iron tablet 22mg, one tablet daily at 5:00pm with half a cup of orange juice. Record review on 5/5/26 of the facility's Medication Procedures Policy stated "Each Rx label should indicate the name of the [client], pharmacist, and licensed independent practitioner; the Rx number, the name of the drug, directions for use (including clear directions for self-administration), if applicable, strength of the drug, quantity, date of issue, name, address and telephone number of the pharmacy, an indication of the number of refills, and drug expiration date." Interview on 5/5/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed if the client uses an over-the-counter medication, staff are supposed to contact the pharmacy and have a label created to place on the package.	W0391		
W0441	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 did not ensure fire drills were conducted during varying times and/or various conditions. The finding is: Record review on 5/4/26 of the facility's fire drills logs revealed the fire drills were completed during the following times with a noted absence of deep sleep hours (1:00am-4:00am): 7:00am-7:00pm shift: 10/7/25 at 4:45pm and 1/12/26 at 4:20pm. 7:00pm-7:00am shift: 5/22/25 at 6:34am, 8/8/25 at 10:25pm, 11/12/25 at 5:57am and 2/26/26 at 10:46pm. Interview on 5/5/26 with the Home Manager and Qualified Intellectual Disabilities Professional (QIDP) confirmed all staff receive emergency preparedness	W0441		

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W0441	Continued from page 5 training that includes procedures for fire drills at their monthly meetings.	W0441		
W0454	<p>INFECTION CONTROL</p> <p>CFR(s): 483.470(l)(1)</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on observations, record reviews and interviews, the facility failed to ensure staff were trained to prevent cross-contamination when administering medications. This affected 2 of 4 audit clients (#2 and #4). The findings are:</p> <p>A. Observations in the home on 5/5/26 at 7:20am, revealed Staff F leaving the medication room carrying prepared medication for client #2. Staff F entered the bathroom while client #2 sat on the toilet and fed her medication.</p> <p>Record review on 5/5/26 revealed client #2's Individual Program Plan (IPP) dated 3/5/26 had language that staff could give client #2 morning medications in her bedroom, since she was noncompliant sometimes cooperating with morning routine.</p> <p>Record review on 5/5/26 revealed client #2's Physician's Orders signed 3/31/26 prescribed Omeprazole 40mg with instructions to take 1 tablet at 7:00am, 45 minutes before breakfast.</p> <p>Interview on 5/5/26 with Staff F revealed she gave medications to client #2 in the bathroom because she did not find her in the bedroom. Staff F explained she had guidelines that client #2 had to receive her medicine at the beginning of the morning schedule.</p> <p>Interview on 5/5/26 with the Home Manager revealed giving medications in the bathroom was a "no no".</p> <p>Interview on 5/5/26 with the Qualified Intellectual Disabilities Professional (QIDP) revealed staff have been permitted to give client #2 her morning medications in her bedroom, per her IPP, but not in the bathroom.</p> <p>B. Observations in the home on 5/5/26 at 7:23am revealed Staff F wearing gloves during the medication administration, keeping them on to scan blister packs of medications plus use a key to open</p>	W0454		

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W0454	<p>Continued from page 6 a lock box container. Staff F did not change the gloves, when she applied a dab of topical ointment on client #4's face, rubbing the solution in her skin.</p> <p>Record review on 5/5/26 of client #4's Physician's Orders signed 3/31/26 prescribed Metronidazole Cream 0.75% to be spread topically to rash on face.</p> <p>Policy review on 5/5/26 of the facility's Standard Precautions dated 11/19/25 revealed indicator for gloves uses "just before touching mucous membrane or contacting blood, body fluids, secretions or excretions. Remove gloves promptly after use and discard before touching non-contaminated items or environmental surfaces, and before providing care to another [client]."</p> <p>Interview on 5/5/26 with Staff F revealed she wore gloves "just for my own sanitation comfort."</p> <p>Interview on 5/5/26 with the Qualified Intellectual Disabilities Professional (QIDP) confirmed contaminated gloves should be changed.</p>	W0454		