PRINTED: 08/28/2019 FORM APPROVED

Division of Health Service Regulation

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			71. 501251110.		_
		FCL026031	B. WING		R 08/13/2019
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIR CODE	
NAME OF T	NOVIDEN ON 3011 EIEN		MDEN ROAD	II., ZII GODE	
FOREST I	HILL GROUP HOME		EVILLE, NC 2830	06	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG	,	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
{C 000}	Initial Comments		{C 000}		
	The Adult Care Licens follow-up survey on 0	sure Section conducted a 8/06/19 and 08/13/19.			
{C 007}	10A NCAC 13G .0206	S Capacity	{C 007}		
	homes have a capacit (b) The total number exceed the number st (c) A request for an ir	131D-2(a)(5), family care ty of two to six residents. of residents shall not nown on the license.			
	modifications shall be department of social s the Division of Facility two copies of blueprin	-			
	of rooms and the second addition, remodeling of showing the use of eaconstruction, plans showing the second removes the second	ond plan indicating the or change in use of spaces ach room. If new all show how the addition			
	will be tied into the ex proposed changes in (d) When licensed ho designed capacity by	the structure. omes increase their the addition to or			
	entire home shall mee regulations.	eting physical plant, the et all current fire safety ne licensee's designee shall			
	evacuation capability from the evacuation c				
		be residing within the home. be submitted through the			
	forwarded to the Cons Division of Facility Se	struction Section of the rvices for review of any amay be required to the			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVE	ΞΥ
701012701	or contraction.	IDENTIFICATION NOTIFICAL	A. BUILDING: _			
		FCL026031	B. WING		R 08/13/20	19
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FOREST I	HILL GROUP HOME		DEN ROAD ILLE, NC 2830	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE CC	(X5) DMPLETE DATE
{C 007}	Continued From page building.	e 1	{C 007}			
	reviews, the facility far Health Service Regul evacuation capabilitie evacuation capability for 2 of 6 residents (F the facility who had p	ns, interviews and record iiled to notify the Division of ation (DHSR) that residents' es were different from the listed on the facility's license desident #1, #2) residing at thysical impairments which sidents from independently				
	01/01/19 through 12/3	s current license effective 31/19 revealed the facility pacity of six ambulatory				
		taff perform a fire drill on and a fire drill was not				
	the facility on 08/13/1 -A fire drill was condu- and the Supervisor-in- Three residents amb of their walkers and coutside in her wheelch from staffResident #2 required her wheelchair.	e residents who resided at 9 at 5:10pm revealed: acted by a Co-Administrator e-Charge (SIC). For every sulated outside with the use one resident pushed herself hair, all with no assistance at staff to push her outside in the discharged from the				

Division of Health Service Regulation

STATE FORM 5899 JDIG13 If continuation sheet 2 of 18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R
		FCL026031	B. WING		08/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FOREST I	HILL GROUP HOME	3510 CAME			
		FAYETTEV	ILLE, NC 2830		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{C 007}	Continued From page	2	{C 007}		
	1. Review of Residen 11/06/18 revealed: -Diagnoses included in hypertensionResident #1's recom Special Care Unit (SC) -Resident #1 was door and constantly disoried Review of Resident #12/12/18 revealed: -Resident #1 was adrighad to be directedResident #1 required assistance with ambut Review of Resident # was no care plan.  Interview with Resident # was no care plan.  Interview with Resident #1 was able only with assistance from admitted to the facility -Resident #1's feet we slightly contracted, ar -Resident #1 was cur move around much a -Resident #1 could st up to a week ago, but more feeding assistant Interview with the two 08/06/19 at 10:45 a.mThe Co-Administrator assessing and admitted in the resident #1 of the resident #1 of the resident #1 of the resident #1 could st up to a week ago, but more feeding assistant Interview with the two 08/06/19 at 10:45 a.mThe Co-Administrator assessing and admitted in the resident #1 of the residen	Alzheimer's dementia and mended level of care was CU). Sumented as non-ambulatory ented.  1's Resident Register dated mitted to facility on 12/14/18. Difficant loss of memory and alation.  1's records revealed there  1's records revealed there			
	up to a week ago, but more feeding assistan Interview with the two 08/06/19 at 10:45 a.m -The Co-Administrato assessing and admitt	t now she needed much note from the facility staff.  Co-Administrators on note in revealed: It is were responsible for ing residents to the facility. The control of the facility is they are licensed for only			

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STATE FORM 5899 JDIG13 If continuation sheet 3 of 18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
			A. BUILDING			
		FCL026031	B. WING		08/1	3/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
FOREST I	HILL GROUP HOME		DEN ROAD			
	I		ILLE, NC 2830			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 007}	Continued From page	2 3	{C 007}			
	admitted to the facility became non-ambulat March 2019.  -They had not notified Resident #1's ambulated -Resident #1 would no get out of the facility in the facility usually heach shift but had assumember to provide or #1.  Interview with Reside 08/06/19 at 2:49 p.m. a call from a social with Resident #1 was sent for failure to thrive periods.	eed assistance from staff to f there were a fire. ad only one staff on duty for signed additional staff ne on one care for Resident on t #1's family member on revealed she had received orker who informed her that it to the hospital on 08/06/19				
	07/18/19 revealed: -Diagnoses included a depression, and diabout -Resident #2's recommendations.	#2's current FL2 dated Alzheimer's, hypertension, etes. mended level of care was n-ambulatory and constantly				
	07/18/18 revealed: -Resident #2 was adr 07/18/18Resident #2 was forg reminders.	2's Resident Register dated nitted to the facility on getful and needed require any assistance with				

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STATE FORM 5899 JDIG13 If continuation sheet 4 of 18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL026031	B. WING		R 08/13/2019	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE. ZIP CODE	1 00/13/2019	
			DEN ROAD	, = 0052		
FUREST	HILL GROUP HOME	FAYETTE	/ILLE, NC 2830	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLE	
{C 007}	Continued From page	e 4	{C 007}			
	ambulation.					
	Review of Resident # 05/28/19 revealed: -Resident #2 required eatingResident #2 was total ambulation, transfer, and grooming -Resident #2 required wheelchair.  Observation on 08/13 Resident #2 was along in a wheelchair with heads on observation.	d extensive assistance with ally dependent for toileting, bathing, dressing, d staff to push her in a 6/19 at 11:45am revealed the in the dining room sitting				
	transfer her and push -Resident #2 was cor	evealed:  walk and required staff to her in a wheelchair.  Ifused most of the time.  equire assistance getting out				
	11:55am revealed: -He and the other Coresponsible for admittheir ambulatory statu-Resident #2 was amadmitted to the facility-Resident #2 had been June 2019Resident #2 could not	ting residents and checking us prior to admission. bulatory when she was				

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STATE FORM 5899 JDIG13 If continuation sheet 5 of 18

Division	of Health Service Regu	lation			
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		ECI 026024	B. WING		
		FCL026031			08/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE	
		3510 CA	MDEN ROAD		
FOREST I	HILL GROUP HOME		EVILLE, NC 28306		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	( - /
PREFIX TAG	,	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
(0.00 <del>=</del> )		_	(0.00=)		
{C 007}	Continued From page	e 5	{C 007}		
	Observation of Resid	ent #2 on 08/13/19 at			
	12:25pm revealed:	511t 1/2 511 557 157 15 Gt			
		ng pushed in her wheelchair			
	by a staff member.	ng pashea in her wheelenaii			
	-	at the staff member and did			
	Hot respond when as	ked what her first name was.			
	Intension, with the bea	realization atoff on 00/42/40			
		usekeeping staff on 08/13/19			
	at 1:20pm revealed:				
	-The facility had a fire				
		be pushed out of the facility			
	-	he Supervisor-in-Charge			
	(SIC).				
		c on 08/13/19 at 1:30pm			
	revealed:				
		en non-ambulatory for the			
	last few months.				
		ot be able to get out of the			
	facility on her own if t	here were a fire.			
	-Resident #2 required	total assistance for			
	ambulation.				
	-The facility had two f	ire drills last week and			
	Resident #2 had to be	e pushed outside in her			
	wheelchair.				
	Interview with a Co-A	dministrator on 08/13/19 at			
	1:45pm revealed:				
		he state regulatory agency			
	regarding Resident #	2's ambulatory status			
	change.				
	-He and the other Co-	-Administrator did not intend			
	to apply for a non-am	bulatory license for the			
	facility.				
	Telephone interview v	with Resident #2's family			
	member on 08/13/19	at 3:35pm revealed:			
	-She had last visited	Resident #2 in July 2019.			
		cative and walked without			

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assistance when she was admitted in July 2018.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		ECI 020024	B. WING		R	
		FCL026031			08/13/2019	$\dashv$
NAME OF PE	ROVIDER OR SUPPLIER		DRESS, CITY, STA I <b>DEN ROAD</b>	TE, ZIP CODE		
FOREST H	HILL GROUP HOME		VILLE, NC 2830	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
{C 007}	Continued From page	e 6	{C 007}			
	-Resident #2 walked she visited her a mon	some with assistance when th ago.				
C 022	10A NCAC 13G .0302 Construction	2 (b) Design And	C 022			
	10A NCAC 13G .0302	2 Design And Construction				
		be planned, constructed, ined to provide the services				
	This Rule is not met a FOLLOW-UP TO TYPE Based on these findin Violation has not been	PE B VIOLATION  ags, the previous Type B				
	reviews, the facility fa met the North Carolin requirements for non- evidenced by 2 of 3 re	ambulatory residents as esidents (Resident #1 and ally impaired, residing in the cuate the facility				
	The findings are:					
	01/01/19 through 12/3	s current license effective 31/19 revealed the facility pacity of six ambulatory				

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STATE FORM 5899 JDIG13 If continuation sheet 7 of 18

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPL	
		FCL026031	B. WING		F 09/4	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	06/1	3/2019
FOREST I	HILL GROUP HOME		DEN ROAD			
		FAYETTEV	ILLE, NC 2830	06		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
C 022	Continued From page	e 7	C 022			
		taff perform a fire drill on and a fire drill was not				
	the facility on 08/13/1 -A fire drill was conduand the Supervisor-in -Three residents amb of their walkers and o outside in her wheelc from staffResident #2 required her wheelchairResident #1 had bee facility on 08/06/19.  1. Review of Residen 11/06/18 revealed: -Diagnoses included hypertensionResident #1's recom Special Care Unit (SC	ulated outside with the use ne resident pushed herself hair, all with no assistance if staff to push her outside in an discharged from the the theorem of the theorem is surrent FL-2 dated. Alzheimer's dementia and mended level of care was				
	12/12/18 revealed: -Resdent #1 was adm 12/14/18Resident #1 had sign had to be directedResident #1 required assistance with ambu Review of Resident # was no care plan.	1's Resident Register dated nitted to the facility on nificant loss of memory and I a wheelchair and lation. 1's records revealed there				
	Observations on 08/0	6/19 at 12:24 p.m. revealed:				

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-Resident #1 was in her room alone in a hospital

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		D
		FCL026031	B. WING		R 08/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FOREST I	HILL GROUP HOME	3510 CAME			
			ILLE, NC 2830		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 022	Continued From page	8	C 022		
	respond to surveyor's entering her roomResident #1 did not r	up. eyes closed and did not verbal communication on respond to verbal and tactile cation aide (MA) to turn over			
	her meals because shaped from staff to sit upright	n. revealed:  go to the dining room to eat  ne would require assistance  it in the wheelchair.  equire total assistance in			
	08/06/19 at 1:16 p.mResident #1 was nor bedResident #1 would n	r medication aide (MA) on revealed: n-ambulatory and stayed in ot be able to get out of the ance from staff if there were			
	08/06/19 at 12:41 p.m -Resident #1 was able only with assistance f admitted to the facility	e to sit up in a wheelchair rom staff when she was / in December 2018.   was slightly contracted,			
	08/06/19 at 10:45 a.m -The Co-Administrato assessing and admitt -They were aware the ambulatory residents.	rs were responsible for ing residents to the facility. at they are licensed for only			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or doring of the state of the s	IDENTIFICATION NOMBER.	A. BUILDING: _		
		FCL026031	B. WING		R 08/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FOREST I	HILL GROUP HOME		DEN ROAD		
		FAYETTEV	ILLE, NC 2830	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
C 022	Continued From page	9	C 022		
	admitted to the facility became non-ambulat March 2019Resident #1 would n get out of the facility i-The facility usually heach shift but had ass	in December 2018 but ory since the beginning of eed assistance from staff to			
		ns, interviews and record nined Resident #1 was not			
	08/06/19 at 2:49 p.m. a call from a social we	nt #1's family member on revealed she had received orker who informed her that to the hospital on 08/06/19 r a Co-Administrator.			
	11:55am revealed Re	dministrator on 08/13/19 at sident #1 was discharged 1/06/19 after the surveyor left			
	07/18/19 revealed: -Diagnoses included a depression, and diabeto-Resident #2's recommendations.	#2's current FL2 dated Alzheimer's, hypertension, etes. mended level of care was n-ambulatory and constantly			
	07/18/18 revealed:	2's Resident Register dated mitted to the facility on getful and needed			

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		_
		FCL026031	B. WING		R 08/13/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
FOREST I	HILL GROUP HOME	3510 CAMI	DEN ROAD		
TORLOTT	ILE GROOF HOME	FAYETTEV	ILLE, NC 2830	06	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
C 022	Continued From page	<del>2</del> 10	C 022		
	-Resident #2 did not rambulation.	require any assistance with			
	Review of Resident # 05/28/19 revealed:	2's Care Plan dated			
	-Resident #2 required eating.	l extensive assistance with			
		ally dependent for toileting, bathing, dressing,			
	and grooming -Resident #2 required wheelchair.	I staff to push her in a			
		ns, interviews, and record nined Resident #2 was not			
	Interview with a medion 08/18/19 at 9:55am re-Resident #2 did not with transfer her and push	evealed: walk and required staff to			
	-Resident #2 was con	fused most of the time. equire assistance getting out			
	11:55am revealed:	dministrator on 08/18/19 at			
	<ul> <li>-He and the other Co- responsible for admitt their ambulatory statu</li> </ul>	ting residents and checking			
	-Resident #2 was am admitted to the facility	bulatory when she was / July 2018.			
	June 2019.	n non-ambulatory since			
	09/04/19, at her next provider, she would b	is had not improved by visit to her primary care e discharged from the			
		ot get out of the facility stance if there were a fire.			

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STATE FORM 5899 JDIG13 If continuation sheet 11 of 18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    CA) PROVIDER   COMPLETED	Division	of Health Service Regu	lation	_			
NAME OF PROVIDER OR SUPPLIER  STREET DODRESS, CITY, STATE, ZIP CODE  3510 CAMDEN ROAD  PRETIX  (RACH DEPOSICE MINEST BE PRICEDED 9*YULL PRETIX (RACH DEPOSICE) MINEST BE PRICEDED 9*YULL TAKE THE GEGLIATORY OF LSC DENTIFYING INFORMATION)  C 022  C Continued From page 11  - The facility would assign an additional staff member to give Resident #2 one-on-one care immediately, because they did not have that previously in place.  Observation of Resident #2 on 08/13/19 at 12:25pm revealed: - Resident #2 stared at the staff member and did not respond when asked what her first name was.  Interview with the housekeeping staff on 08/13/19  at 1:20pm revealed: - The facility had a fire drill on 08/09/19 Resident #2 had to be pushed out in her wheelchair by he scient #2 had been non-ambulatory for the last few months Resident #2 had been non-ambulatory for the last few months Resident #2 would not be able to get out of the facility on her own if there were a fire Resident #2 required total assistance for ambulation.	STATEMENT	Γ OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
Second   S	AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPL	ETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3510 CAMDEN ROAD  FAVETTEVILLE, NC 28306  PROVIDERS PLAN OF CORRECTION  (ASJ)  REGULATORY OR LSC IDENTIFYING INFORMATION)  C 022  Continued From page 11  The facility would assign an additional staff member to give Resident #2 one-on-one care immediately, because they did not have that previously in place.  Observation of Resident #2 on 08/13/19 at 12:25pm revealed:  -Resident #2 stared at the staff member and did not respond when asked what her first name was.  Interview with the housekeeping staff on 08/13/19 at 1:20pm revealed:  -The facility had a fire dill on 08/09/19Resident #2 had been non-ambulatory for the last few months.  -Resident #2 would not be able to get out of the facility on her own if there were a fire.  -Resident #2 would not be able to get out of the facility on her own if there were a fire.  -Resident #2 required total assistance for ambulation.				A. BOILDING			
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  3510 CAMDEN ROAD  FAVETTEVILLE, NC 28306  PROVIDERS PLAN OF CORRECTION  (ASJ)  REGULATORY OR LSC IDENTIFYING INFORMATION)  C 022  Continued From page 11  The facility would assign an additional staff member to give Resident #2 one-on-one care immediately, because they did not have that previously in place.  Observation of Resident #2 on 08/13/19 at 12:25pm revealed:  -Resident #2 stared at the staff member and did not respond when asked what her first name was.  Interview with the housekeeping staff on 08/13/19 at 1:20pm revealed:  -The facility had a fire dill on 08/09/19Resident #2 had been non-ambulatory for the last few months.  -Resident #2 would not be able to get out of the facility on her own if there were a fire.  -Resident #2 would not be able to get out of the facility on her own if there were a fire.  -Resident #2 required total assistance for ambulation.						l F	1
NAME OF PROVIDER OR SUPPLIER  3510 CAMDEN ROAD  FAYETTEVILLE, NC 28306  ((44) ID SUMMARY STATEMENT OF DEFICIENCIS (EACH DEFICIENCY MUST BE PRECEDED BY FULL (FREGULATORY OR LSC IDENTIFYING INFORMATION)  C 022  C 022  C 01tinued From page 11  - The facility would assign an additional staff member to give Resident #2 one-on-one care immediately, because they did not have that previously in place.  Observation of Resident #2 on 08/13/19 at 12:25pm revealed:  - Resident #2 was being pushed in her wheelchair by a staff member.  - Resident #2 was being pushed on 08/13/19 at 1:20pm revealed:  - The facility had a fire drill on 08/09/19.  - Resident #2 dat to be pushed out in her wheelchair by the Supervisor-in-Charge (SIC).  Interview with the SIC on 08/13/19 at 1:30pm revealed:  - Resident #2 does not verbally communicate.  - Resident #2 does not verbally communicate.  - Resident #2 had been non-ambulatory for the last few months.  - Resident #2 would not be able to get out of the facility on her own if there were a fire.  - Resident #2 required total assistance for ambulation.			FCI 026031	B. WING		1	
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wheelchair.			F			ľ	
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			di-i-tt 00/40/40				
Interview with a Co-Administrator on 08/13/19 at							
1:45pm revealed he and the other							
Co-Administrator did not intend to apply for a		Co-Administrator did	not intend to apply for a				
non-ambulatory license for the facility.						ľ	
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Telephone intensions with Decident #01s femily		Tolombone intensi	with Decident #0!- f:				
Telephone interview with Resident #2's family							
member on 08/13/19 at 3:35pm revealed:							
-She had last visited Resident #2 in July 2019.		-She had last visited I	Resident #2 in July 2019.				
-Resident #2 was talkative and walked without							

Division of Health Service Regulation

STATE FORM 5899 JDIG13 If continuation sheet 12 of 18

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		IDENTIFICATION NUMBER:	A. BUILDING: _					
			B. WING R		l R			
		FCL026031			08/13/2019			
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZIP CODE				
TVAINE OF T	3510 CAMDEN ROAD							
FOREST I	HILL GROUP HOME		VILLE, NC 2830	06				
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTIO	N (VE)			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE			
C 022	Continued From page	e 12	C 022					
	assistance when she was admitted in July 2018Resident #2 walked some with assistance when she visited her a month agoShe had not spoken with Resident #2's doctor but she was aware that Resident #2 had been slowly declining since she was admittedShe doubted that Resident #2 would know what to do if there were a fire drill.  The facility failed to be equipped and maintained in a manner to assure the safety of 2 of 3 sampled residents (#1, #2) who had physical impairments that could not evacuate independently in an emergency. The facility's failure was detrimental to the safety and welfare of the residents and constitutes an Unabated Type B Violation.  The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/19 for this violation.							
{C 207}	and Medical Examina 10A NCAC 13G .0702 Medical Examination (c) The results of the to be entered on the I Medicaid Program Lo MR-2, North Carolina Retardation Services, following: (4) If the information of clear or is insufficient supervisor-in-charge for clarification in order	2 Tuberculosis Test and  complete examination are FL-2, North Carolina ong Term Care Services, or Medicaid Program Mental which shall comply with the on the FL-2 or MR-2 is not the administrator or shall contact the physician	{C 207}					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. DUILDING: _	A. BUILDING:		R	
FCL026031		B. WING	B. WING		3/2019	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
FOREST H	IILL GROUP HOME		MDEN ROAD	00		
0/0/15	SHMMADV ST	ATEMENT OF DEFICIENCIES	EVILLE, NC 2830	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 207}	Continued From page	e 13	{C 207}			
	reviews, the facility fathe recommended Le residents (#1, #3).  The findings are:  1.Review of Resident 11/06/18 revealed: -Diagnoses included / hypertensionResident #1's recom Special Care Unit (SC Review of Resident # was no care plan.  Review of Resident # 12/12/18 revealed: -Resident #1 was adr 12/14/18Resident #1 had sign had to be directedResident #1 required assistance with ambut Based on observation reviews it was determinterview able.  Interview with Reside 08/06/19 at 2:49 p.m. a call from a social was	#1's current FL-2 dated Alzheimer's dementia and mended level of care was CU).  1's records revealed there  1's Resident Register dated mitted to the facility on ifficant loss of memory and I a wheelchair and ilation.  as, interviews and record ined Resident #1 was not  1's family member on revealed she had received orker who informed her that it to the hospital on 08/06/19				
	Interview with a Co-A	dministrator on 08/13/19 at				

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11:55am revealed:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	ECI 026034 B. WING		R 09/43/2049				
NAME OF D		FCL026031		TE 710 0005	08/13/2019		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  3510 CAMDEN ROAD						
FOREST I	HILL GROUP HOME		ILLE, NC 2830	06			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE		
{C 207}	Continued From page	e 14	{C 207}				
	and signed by the phywere updatedResident #1 was disconsideredResident #1 was disconsidered. 2.Review of Resident 08/09/18 revealed: -Diagnoses included a seizure disorder, atax-Resident #3 did not hof care (LOC)Resident #3's previous was skilled nursing farevealed: -Resident #3 did not reating, ambulation, trained grooming	#3's current FL-2 dated dementia, depression, tia and hypertension. nave a recommended level us LOC (prior to admission)					
	08/08/18 revealed: -Resident #3 had sign had to be directedResident #3 ambulat  Interview with a Co-A 5:00pm revealed: -He was in charge of and signed by the phywere updatedHe did not know Resrecommended LOCResident #3's family doctor appointments.	3's Resident Register dated inficant loss of memory and led with use of a walker. dministrator on 08/13/19 at getting all FL2s completed lysician and ensure they lident #3 did not have a member took her to her lesident #3's primary care					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		A. Boilbino.		R				
		FCL026031	B. WING		1	3/2019		
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
FOREST H	HILL GROUP HOME	3510 CAME						
	CLIMMADY CT		ILLE, NC 2830					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE		
{C 236}	Continued From page	: 15	{C 236}					
{C 236}	10A NCAC 13G .0802	2 (a) Resident Care Plan	{C 236}					
	(a) A family care hom is developed for each the resident assessm 30 days following adn .0801 of this Section. individualized, written for each resident.  This Rule is not met assed on record revie assure that a care pla days of admission for resided at the facility.	ew, the facility failed to n was developed within 30						
	11/06/18 revealed: -Diagnoses included / hypertensionResident #1's recom Special Care Unit (SC	1's current FL-2 dated Alzheimer's dementia and mended level of care was CU). cumented as non-ambulatory						
	and constantly disorie							
	12/12/18 revealed: -Resident #1 was adr 12/14/18.							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
FCL026031 B. WING		71. 201221110.		R		
			08/13/2019			
NAME OF PR	ROVIDER OR SUPPLIER	TE, ZIP CODE				
FOREST H	IILL GROUP HOME		DEN ROAD			
			ILLE, NC 2830			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
{C 236}	Continued From page 16		{C 236}			
	-Resident #1 was in h towards her left side i bedrails upResident #1 had her respond to surveyor's entering her roomResident #1 did not in stimulation by a mediation eat her lunch.  Based on observation reviews it was determine interviewable.  Interview with the two 08/06/19 at 10:45 a.mThe Co-Administration assessing and admitted that included a care primary care physicial resident #1 was sen admitted to the facility became non-ambulated March 2019Resident #1 did not it physician because shutter that included a care primary care physicial had been trying the side of the facility became non-ambulated to the facility became had been trying the side of the sid	eyes closed and did not everbal communication on respond to verbal and tactile cation aide (MA) to turn over as, interviews and record ained Resident #1 was not a Co-Administrators on revealed: rs were responsible for ing residents to the facility, alan signed by the residents' n. mi-ambulatory when she was a in December 2018 but ory since the beginning of the was under hospice care. It is to get in touch with the indid been unable to reach him				
{C 912}	G.S. 131D-21(2) Dec	laration of Residents' Rights	{C 912}			
	Every resident shall h 2. To receive care an adequate, appropriate	ration of Resident's Rights lave the following rights: Id services which are e, and in compliance with state laws and rules and				

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STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
A. BUILDING:									
FCL026031		B. WING		R 08/13/2019					
NAME OF PR	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
FOREST H	IILL GROUP HOME	3510 CAMI		ne					
FAYETTEVILLE, NC 28306  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE			
{C 912}	Continued From page	e 17	{C 912}						
	regulations.								
	reviews, the facility fareceived care and set appropriate and in cofederal and state laws related to design and.  The findings:  Based on observation reviews, the facility farmet the North Carolin requirements for nonevidenced by 2 of 3 rewidenced by	ns, interviews and record illed to ensure residents rvices which are adequate, impliance with relevant and rules and regulations construction.  Ins, interviews and record illed to assure the building a Building Code ambulatory residents as esidents (Resident #1 and ally impaired, residing in the cuate the facility							

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