

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G114	COMPLETE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/10/2018
		A. BUILDING	
		B. WING	

NAME OF PROVIDER OR SUPPLIER FOREST CREEK GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 5117 FOREST CREEK DRIVE RALEIGH, NC 27606
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(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
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W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3)	W 125	This deficiency will be corrected by the following actions:	
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	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the restrictive behavior support plan (BSP) for 1 of 3 audit clients (#5) was not implemented with written consent from both "co-guardians." The finding is:</p> <p>The BSP was not implemented with consent of both co-guardians.</p> <p>Review on 4/10/18 of client #5's BSP consent dated 1/10/18 was signed by one legal guardian. However review of the guardianship papers dated August 7, 1998 revealed there are two legal co-guardians.</p> <p>Interview with the group home manager on 4/10/18 revealed the guardians were aware they both needed to sign consents and this one consent was "missed." He confirmed the BSP consent for client #5 was only signed by one of his legal guardians.</p>		<p>A. QIDP will review all documents to ensure all documents needing guardian consents have the said signatures affixed</p> <p>B. If need be, QIDP will contact current guardian(s) to notify them and obtain missing guardian consents.</p> <p>C. QIDP will monitor monthly.</p> <p style="text-align: center;">DHSR - Mental Health APR 25 2018 Lic. & Cert. Section</p>	6/8/18
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W 352	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(2)	W 352	See page 2	6/8/18
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Duke Myabeza</i>	TITLE <i>Operations Manager</i>	(X6) DATE <i>4/23/18</i>
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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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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G114	MULTIPLE CONSTRUCTION A BLDG _____ B WING _____		(X3) DATE SURVEY COMPLETED 04/10/2018
NAME OF PROVIDER OR SUPPLIER FOREST CREEK GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(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 352	Continued From page 1 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to assure 1 of 3 clients (#4) received a comprehensive dental examination at least annually. The finding is: Client #4 did not have a full dental examination at least annually. Review on 4/10/18 of client #4's record revealed a dental note dated 10/26/17 which noted "limited examination." It further noted an examination should be scheduled in the "OR." Additionally a 3/1/17 dental note stated the "Patient was not cooperative" for an exam. During an interview on 4/10/18, management called the dental office who confirmed he is not cooperative for comprehensive dental exams unless under anesthesia. Management confirmed client #4 has not had such done in over a year bt an appointment is scheduled.	W 352	This deficiency will be corrected by the following actions: A. Clinical Supervisor/RN/ and/or Residential manager will ensure every resident is scheduled and obtain a full dental examination for each calendar year. B. If need bc, the IDT team will review the client dental service needs monthly C. Clinical Supervisor/RN will monitor medical consults monthly. D. Home Supervisor will monitor medical consults weekly.	6/8/18	