STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G192	A. BUILDING _____ B. WING _____	08/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH GROUP HOME #2	8460 BELEWS CREEK ROAD BELEWS CREEK, NC 27009

(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 129	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure the privacy rights of 1 of 4 sampled clients (#1). The finding is: Medication observations on 8/28/18 at 7:30 AM in the home revealed client #1 exiting the medication administration closet into the home's kitchen area. Continued observation revealed staff to verbally prompt client #1 to announce his blood glucose glucometer level to the staff who was in the common area of the kitchen/dining room of which he did. Further observations revealed a housemate client (#5) was seated at the dining table when client #1 announced his blood glucose level and was able to hear this private information announced. Interview on 8/28/18 at 7:55 AM with staff revealed client #1 does not have a program to announce his blood glucose levels to staff, rather it is just what he does so the staff who is preparing meals can "adjust his carbs." Further interview revealed staff adjusts client #1's carbohydrates at meals according to his blood glucose levels. Review on 8/28/18 of client #1's records revealed a physician's order signed 5/28/18 with "1800 cal ADA Diet...DO NOT RATION HIS FOOD. IF	W 129	W129 The Nurse and the Qualified Professional will in-service staff on ensuring client #1 and all the persons supported are provided privacy during Medication Administration. The clinical team will monitor 2 times a week for a period of one month and then on a routine basis through Medication Observations to ensure privacy during medication administration. In the future, the Qualified Professional will ensure staff are trained to ensure privacy of all People We Support during medication administration. By: 10/26/18 DHSR - Mental Health SEP 06 2018 Lic. & Cert. Section	10/26/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	DP	9/4/18

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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W 129	Continued From page 1 BLOOD SUGAR IS HIGH, DO NOT DECREASE HIS CARBOHYDRATE INTAKE, BUT RATHER CALL THE NURSE WHO WILL CALL DR..." Review on 8/28/18 of client #1's rights assessment dated 1/11/18 regarding privacy and the confidentiality of personal information including spoken information revealed client #1 needs "FULL" support because he "does not understand the right and needs full support from others to ensure the right is exercised and protected." Interview on 8/28/18 with the qualified intellectual disabilities professional (QIDP) verified client #1 does not have a program to announce his blood glucose levels to staff. QIDP further confirmed client #1 should not have been prompted by staff to announce his blood glucose level in front of others to maintain his right to privacy.	W 129		
W 227	INDIVIDUAL PROGRAM PLAN 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: The facility failed to assure the person centered plans (PCP's) for 2 of 4 sampled clients in the home (clients #1 and #6) included objective training to meet the clients' needs related to use of their prescription eyeglasses as evidenced by observations, interviews and record reviews. The findings are:	W 227		

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W 227	Continued From page 2 A. The facility failed to assure the person centered plan (PCP) for client #1 included objective training to meet his needs related to use of his prescription eyeglasses. Afternoon observations in the group home on 8/27/18 at approximately 4:55 PM-5:25 PM revealed client #1 to be participating in a housemates' birthday celebration by conversing with his housemates, sitting at the dining room table with his housemates and a guest, and eating his dinner meal. Further observations revealed client #1 was not wearing his prescription eyeglasses during these activities nor was he prompted by staff to retrieve his eyeglasses during this period. Continued observations in the group home on 8/28/18 from 7:05 AM until 7:45 AM revealed client #1 to take his morning medications and to watch TV in the living room. At approximately 7:45 AM client #1 was prompted to the table to eat his breakfast meal by staff, who simultaneously prompted client #1 to retrieve his prescription eyeglasses from his bedroom, which he did. Subsequent observations at 7:50 AM revealed client #1 to remove his eyeglasses and leave them on the dining table during his breakfast meal and later as he entered the living room to watch TV. Observations at 8:15AM revealed staff to prompt client #1 to retrieve his glasses from the dining table at which time he did so. Client #1 then placed his glasses on a side table in the living room where he continued to watch TV. Subsequent observations at 8:30 AM revealed staff to again prompt client #1 to put on his glasses at which time he did so. During the morning observations client #1 was observed to wear his eye glasses for approximately 10 minutes total out of the 100 minutes observed,	W 227	W227 A team meeting will be held to discuss client #1 and client #6 use of prescription corrective eyeglasses. The Habilitation Specialist will ensure the need for client #1 and 6 to wear eye glasses is addressed in a formal program. The Qualified Professional will revise the Person Centered Plan to reflect the objectives for Client #1 and #6. The Habilitation Specialist will in-service the staff on the formal program. The clinical team will monitor to ensure client 1 and 6 appropriately wears eyeglasses 2 times a week for a period of one month and then on a routine basis through Interaction Assessments. In the future, the Qualified Professional will ensure all identified training needs for all People Supported are addressed through formal programs and updated in the Person Centered Plan. By: 10/26/18	10/26/18

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W 227	Continued From page 3 and he needed to be prompted to retrieve his eyeglasses at various times from various places in the home. Record review on 8/28/18 for client #1 contained a current PCP confirming that client #1 requires prescription corrective eyeglasses. Interview with the group home staff revealed client #1 does not like to wear his glasses and often leaves them in his room or other places in the home. Continued interview with the facility qualified intellectual disabilities professional (QIDP) confirmed client #1 requires prescription eyeglasses as part of his adaptive equipment, however client #1 struggles to wear his glasses consistently, but is seen wearing them at times at the day center. Further interview with the QIDP verified that no active treatment training program has been put in place to assist client #1 with wearing and caring for his glasses consistently, as prescribed. B. The facility failed to assure the person centered plan (PCP) contained objective training to meet client #6's needs related to use of his prescription eyeglasses. The finding is: During evening observations in the group home from 4:55 PM until approximately 5:25 PM on 8/27/18 client #6 was observed to be participating in celebration of a housemate's birthday by having dinner together in the group home, conversing with others, housemates and a guest at the dining table. During these evening observations client #6 was not observed wearing his prescription glasses, nor was he prompted to wear his glasses at any time.	W 227		

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W 227	Continued From page 4 Continued observations in the group home on 8/28/18 from 7:10 AM to approximately 7:30 AM revealed client #6 to make coffee in the kitchen and help prepare his morning breakfast. Further observations revealed client # 6 to be prompted at approximately 7:30 AM by staff to retrieve his glasses from his bedroom. Continued observations revealed client #6 to wear his glasses during his breakfast meal and return to his room at approximately 8:05 AM where he took his glasses off and left them. Subsequent observations revealed staff to again prompt client #6 to get his glasses from his room and put his glasses back on, which he did at approximately 8:20 AM. Record review on 8/27/18 for client #6 revealed a current PCP confirming client #6 had recently been prescribed new bifocal corrective lenses as part of his adaptive equipment. Interview with the facility staff on 8/28/18 at 8:30 AM in the group home revealed client #6 does not like to wear his eyeglasses at home and will often leave them in his room instead of wearing them as prescribed. Interview with the QIDP on 8/28/18 at approximately 1:30 PM confirmed client #6 is prescribed corrective prescription lenses as part of his adaptive equipment. Continued interview with the facility QIDP confirmed client #6 recently got a new pair of corrective bifocal lenses "which he usually wears at the day center and seemed excited to have." Further interview with the QIDP confirmed no training objectives have been put in place to support client #6 with wearing his corrective glasses consistently as prescribed, both at home and at the day center.	W 227		

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W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, record review and interview nursing services failed to address medical recommendations for 1 of 4 sampled clients (#6) related to use of a gait belt. The finding is: Observations during the 8/27/18-8/28/18 survey revealed client #6 to have a laceration to the back of his head/scalp measuring approximately 2-3 inches in length, which was a result of a "fall in the mall last Friday 8/24/18" per group home staff. This fall resulted in an emergency medical care visit and required 3-4 medical staples to close the head wound. Continued observations over the survey period revealed client #6 to wear a looped gait belt and to utilize a roller walker inside the group home, at the day center, and outside of the group home while walking to the van, on uneven and even surfaces. Further observations during the 8/27/18-8/28/18 survey period revealed client #6 to ambulate with an unsteady gait, occasionally bumping into people or objects in the home, utilizing only his roller walker to steady himself. At no time during the 2 day observation period was staff seen to utilize the gait belt to assist client #6 in his ambulation, inside or outside of the group home, or while client #6 ambulated on even or uneven surfaces. Review of facility incident reports for client #6 on 8/27/18 and 8/28/18 revealed client #6 has had 5 incident reports related to ambulation, balance,	W 331	W331 The Qualified Professional will follow up with the physical therapist to assess client #6 ambulation guidelines to include use of the gait belt. The Qualified Professional will revise the Person Centered Plan to reflect changes and in-service staff per physical therapist recommendations. The clinical team will monitor 2 times a week for a period of one month and then on a routine basis through Interaction Assessment. In the future, the Qualified Professional will ensure all staff are trained and implementing ambulation guidelines per physical therapist recommendations. By: 10/26/18	10/26/18

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W 331	Continued From page 6 and unsteady gait on the following dates within the past 5 months: (1) 3/20/18 client #6 fell and hit his head in the bathroom which resulted in a laceration to his head that required an emergency medical care visit where he received 1 suture (staple) to close his head wound; (2) 5/23/18 client #6 tripped and fell coming out of the bathroom which was reported as "no injury"; (3) 5/31/18 client #6 ran into a door way which caused an abrasion to his upper right arm; (4) 6/31/18 client #6 hit his face on the washing machine top cover as he loaded his laundry; and (5) 8/24/18 client #6 fell backwards hitting the floor, as he was walking in the mall, causing an injury to the back of his head of which required an emergency medical care visit where he received 3 sutures to the back on his head. Record review for client #6 on 8/28/18 revealed an occupational therapy evaluation dated 5/30/18 stating client #6 "requires a gait belt due to unsteady gait and disorganized motor planning." Continued record review revealed a current physical therapy evaluation with "has supervised ambulation activities." Subsequent record review revealed a current person center plan (PCP) dated 5/16/18 which stated client #6 "uses a roller walker and a gait belt, for his abnormal gait and spasticity, he is prone to falls, -requires uses of a gait belt." Interview with the group home manager revealed client #6's gait belt is not routinely used to assist client #6 with ambulation inside or outside of the group home, instead it is used to attempt "to catch client #6 when he drops to the floor as a result of him wanting attention." Continued interview with group home staff confirmed staff is not sure how or when to utilize the gait belt to	W 331		

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W 331	Continued From page 7 assist client #6 "since he uses his walker." Subsequent interview with the group home manager revealed "staff was not holding client #6's gait belt when client #6 fell backwards last week while walking in the mall since he was using his walker." Interview with the qualified intellectual disabilities professional (QIDP) confirmed client #6 has 5 documented incidents from 3/18-8/18 related to unsteady gait, lack of balance, and other ambulation needs, two of which resulted in head injuries that required sutures and other medical attention. Continued interview with the facility QIDP confirmed there has been no recent min-team meetings to address these incidents, and no recent training has been provided to staff on use of the gait belt for client #6. Further interview with the QIDP confirmed staff should be holding client #6's gait belt when he is walking in the mall, or on outings and on uneven surfaces to help to prevent falls.	W 331		
W 475	MEAL SERVICES CFR(s): 483.480(b)(2)(iv) Food must be served with appropriate utensils. This STANDARD is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure an adaptive eating utensil (t-rocker knife) was provided for 1 sampled client (#4). The finding is: Observations in the group home during the dinner meal on 8/27/18 at approximately 5:05 PM revealed client #4 eating his dinner meal of spaghetti and meat sauce, salad, and a whole	W 475		

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W 475	Continued From page 8 piece of garlic toast, along with beverages. Client #4 was observed to have a regular fork, knife, and spoon to eat his meal. There was no rocker knife present at client #4's place setting to utilize with his meal. Continued observations on 8/28/18 at approximately 7:40 AM at the breakfast meal revealed client #4 to eat his breakfast meal of eggs, breakfast beverages and a whole piece of toast which he speared with his fork, and ate in bites from his fork. Further observations of the breakfast meal revealed client #4 to have a regular knife, fork, and spoon to eat his breakfast meal. There was no rocker knife present at client #4's place setting for him to cut his breakfast toast. Record review on 8/27/18-8/28/18 for client #4 revealed a person centered plan (PCP) dated 12/13/17 which contained an occupational therapy evaluation dated 11/17 which stated "client #4 has a regular diet with "bite size pieces and use of a t-rocker knife with his meals." Interview with the group home manager and the qualified disabilities professional confirmed that client #4 should have a T-rocker knife at his place setting for each of his meals to cut his food items as needed.	W 475	W475 The Habilitation Specialist will train and in service all staff on client #4's use of adaptive equipment during meal time. The clinical team will monitor 2 times a week for one month and then on a routine basis through Mealtime Assessments to ensure client #4's use of adaptive equipment is being followed as ordered. In the future, the Qualified Professional will ensure all staff are trained per the Person Centered Plan to ensure all persons supported appropriate use of adaptive equipment. By: 10/26/18	10/26/18