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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G114	A. BUILDING _____ B. WING _____	04/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST CREEK GROUP HOME	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 137	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 1 of 4 audit clients (#5) had the right to appropriate fitting clothing. The finding is: Client #5 did not wear clothes which fit appropriately. During observations throughout the survey on 4/15 - 16/19, client #5 wore loose fitting jeans. Further observations revealed client #5's jeans hug very low on his hips, revealing his underwear and buttocks. Client #5 was observed pulling up his jeans while walking around the day program and his home. Further observations revealed client #5 was not wearing a belt. Review on 4/15/19 of client #5's community/home life assessment dated 4/2019 revealed he is dependent upon staff to check his appearance. During an interview on 4/16/19, Staff D revealed client #5 has a white colored belt. Additional interview revealed two white colored belts were located in another clients' bedroom; but neither belt had a name on it. During an interview on 4/16/19, Staff C revealed he has seen client #5 wear a belt in the past.	W 137	This deficiency will be corrected by the following actions: A. Clinical Supervisor and/or Home Manager will list (Asset List updated quarterly)the appropriate clothing sizes for each consumer to ensure consistency and appropriate fits. Clinical Supervisor and/or Home Manager will also list (in the ISP listed as Clothing Preferences) alternative clothing options for any individual who refuses to wear certain clothing items (i.e. belts). B. Any clothing items that do not fit properly, the Home Manager will ensure that the proper alterations have been completed or new clothing items have been purchased. C. Direct Support Professionals will complete a Daily Appearance Checklist at least once per day to ensure consumers are properly clothed/groomed. D. Home Manager will monitor 3x/weekly to ensure that everyone is appropriately dressed and that their clothing fits properly. E. Clinical Supervisor will monitor 2x/weekly. RECEIVED MAY 07 2019 DHSR-MH Licensure Sect	6/15/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

GA/CD | Program Manager | 4/30/19

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 137	Continued From page 1 During an interview on 4/16/17, the home manager (HM) revealed he assisted client #5 to change his clothes and put on a pair of sweat pants. The HM stated, "[Client #5] prefers to wear sweat pants." When asked, the HM reported the fact that client #5 prefers to wear sweat pants was not documented in his record.	W 137	Please see Page 1.	
W 247	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure 1 of 4 audit clients (#2) was provided the opportunity of choice. The finding is: Client #2 was not afforded choice and freedom of movement in his home environment. During morning observations in the home on 4/16/19, client #2 was observed sitting on the couch. At 7:18am, client #2 stood up and walked into the kitchen. Further observations revealed Staff C told client #2, "No" and pointed back at the couch for him to sit down. Client #2 sat back down on the couch. Further observations revealed the kitchen table was set for breakfast for 20 minutes, prior to client #2 going into the kitchen. During an interview on 4/16/19, Staff C revealed client #2 has to eat with "someone" while he is in the kitchen. Further interview revealed Staff C could be the "someone" in the kitchen with client #2. Additional interview revealed all the clients	W 247	This deficiency will be corrected by the following actions: A. Clinical Supervisor will In-service and train staff at Forest Creek regarding client rights to include, but not be limited to, the freedom to move about the home. This training will also include Active Treatment for each consumer based on their stated goals and on what is listed in the ISP. B. Direct Support Professionals will document their training on form F10.10 Client Specific Competencies. That form will then be filed in the training binder at the group home. C. Clinical Supervisor will monitor staff 2x/weekly. D. Home Manager will monitor staff 3x/weekly.	6/15/19

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W 247	Continued From page 2 have to eat together. Review on 4/16/19 of client #2's communication update dated 6/28/18 stated, "Recommendations:...2. Acknowledge all of [Client #2's] communicative intent at all times...." During an interview on 4/16/19, the home manager (HM) stated client #2 does have free movement within his environment. Further interview revealed all the clients do not have to eat together. During an interview on 4/16/19, the qualified intellectual disabilities professional (QIDP) revealed client #2 does have free movement within his environment.	W 247	Please see Page 2.	
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure each client received a continuous active treatment plan consisting of needed interventions and services identified in the individual program plan (IPP) in the area of choice making. This affected 1 of 4	W 249	This deficiency will be corrected by the following actions: A. Clinical Supervisor will in-service and train staff at Wake Enterprises regarding proper program implementation. This training will include, but not be limited to, Active Treatment based on the consumers ISP as well as BSP guidelines. This training will also address program documentation. B. Staff will document their training on form F10.10 Client Specific Competencies. This form will be filed in the training binder at the group home. B. Clinical Supervisor will monitor Wake Enterprises 2x/monthly. C. Home Manager will monitor Wake Enterprises weekly.	6/15/19

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W 249	Continued From page 3 audit clients (#5). The finding is: Client #5 was not offered opportunities for choice making. During morning observations at the day program on 4/15/19 from 10:00am until 11:20am, client #5 was observed sleeping on a bean bag in the corner of the work area. Further observations revealed the program manager standing near client #5 at 10:30am and calling his name; there was no response from client #5. At 11:21am, client #5 was observed walking around the work area. Client #5 was back laying down on the bean bag. Further observations at 11:30am, client #5 raised up his head and made a grunting noise and Staff A told him "No" and he laid back down on the bean bag. At 11:42am, client #5 was walking around the work area and Staff A told him to touch his name on a bulletin board, which he did and went back to lay down on the bean bag. Staff B called client #5's name at 11:45am and asked him to sweep the floor, he did not look up or get up from the bean bag. Client #5 stood up at 11:50am and walked down the hallway towards the dining area. At 12:30am after lunch client #5 went back to the work area and laid back down on the bean bag in the corner. Staff A offered client #5 his toothbrush to brush his teeth; client #5 refused and continued laying on his bean bag. During an interview on 4/15/19, Staff A revealed client #5 refuses to do any of the work which is offered to him or sit at the table with the other clients in his group. Further interview revealed the group home does know client #5 is not participating in any of the activities he is offered while at the day program. Staff A stated she told client #5 "No" because that "noise means he's	W 249	Please see Page 3	

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W 249	Continued From page 4 about to have a behavior." During an interview on 4/15/19, Staff B stated it is just normal for client #5 to lay down on the bean bag and not participate in any activities which are offered to him. Further interview revealed he "might" sweep sometimes. During an interview on 4/15/19, the program manager at the day program revealed client #5 will lay on the bean bag throughout most the day while he is there. Further interview revealed client #5 will be offered the opportunities to play games, go outside or go into the activity room to paint. The program manager stated the group home does know how client #5 will not participate in any of the activities which are offered to him. Review on 4/15/19 of client #5's IPP dated 4/9/19 stated, "It is difficult to get him involved in activities at...work. He is very defiant at times, he gets angry when staff tries to get him involved. Staff will continue to offer him choices and motivate him to take part in all aspects of his life. He refuses to engage with his peers at work and he well be given more choices in activities so that he may enjoy things such as making coffee, taking the trash out at work as a reinforce to get [Client #5] to actively engaged." During an interview on 4/16/19, the home manager (HM) revealed client #5 enjoys making coffee, taking out the trash and sweeping the floor while at the day program. During an interview on 4/16/19, the qualified intellectual disabilities professional (QIDP) revealed she and the HM have been out to the day program to observe client #5. During their	W 249	Please see Page 3	

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W 249	Continued From page 5 observations client #5 will be offered activities, but refuses to participate.	W 249	Please see Page 3.	
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that the infections control prevention procedures were carried out. This potentially affected all clients at the day program and residing in the home. The findings are: Precautions were not taken to promote client health and prevent possible cross-contamination. 1. During afternoon observations at the day program on 4/15/19 at 10:00am, client #5 was observed laying on a bean bag with his left hand down inside of his jeans. At 11:22am. client #5 went into the bathroom, the surveyor stood outside of the closed bathroom door and heard no water running; client #5 exited the bathroom at 11:25am and went to lay back down on the bean bag. Staff A redirected client #5 to wash his hands; client #5 refused. At no time was client #5 offered hand sanitizer. Further observations revealed client #5 walking around the work floor shutting a door, touching a magazine and a container of leisure activities. Further observations revealed client #5 touching the refrigerator door to obtain his lunch tote. Additional observations revealed other clients and staff touching the same refrigerator door	W 455	This deficiency will be corrected by the following actions: A. Clinical Supervisor will coordinate with Wake Enterprises to review, train, and in-service staff on OSHA guidelines and safety precautions to avoid cross-contamination. B. Clinical Supervisor and/or Home Manager will appropriately label personal care items with the name/initials of the person to whom they belong to avoid potential cross-contamination. C. Clinical Supervisor will monitor for OSHA and safety precautions 2x/monthly at the home and at the workshop. D. Home Supervisor will monitor for OSHA and safety precautions weekly at the home and at the workshop.	6/15/19

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W 455	Continued From page 6 afterwards. 2. During lunch observations at the day program at 12:01pm, other client who was sitting across from client #5 was observed to be eating out of client #5's fruit cup, with a spoon he had previously used to eat his lunch. Further observations revealed Staff B taking the fruit cup from the client and placing it behind client #5's lunch tote which was beside him on the table. At 12:12pm. client #5 was observed eating potato chip pieces off the floor on four separate occasions. At 12:15pm, client #5 was observed eating the rest of the fruit cup. At no time was client #5 redirected from eating off the floor. During an interview on 4/15/19, Staff B reported client #5's fruit cup should have been thrown away after the other client ate from it. Further interview revealed client #5 should have been redirected to not eat off the floor. During an interview on 4/15/19, the program manager at the day program revealed client #5 should have been offered hand sanitizer. Further interview revealed the hand sanitizer is not located out on the work floor, because there are clients who might ingest it. The program manager reported the staff know where the hand sanitizer is located and should have offered it to client #5. 3. During observations in the home on 4/15/19 at 5:03pm, client #5 obtained a pair of nail clippers from a container of pens which was located on top of the file cabinet where the medications are located. Observation of the nail clippers revealed there was no name of the nail clippers to indicate who they belonged to.	W 455	Please see Page 6.	

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W 455	Continued From page 7 During an interview on 4/15/19, Staff C confirmed there was not a name on the nail clippers which were used to cut client #5's finger nails. During an interview on 4/15/19, the home manager (HM) confirmed there was not a name on the nail clippers which were used to cut client #5's finger nails.	W 455	Please see Page 6.	