PRINTED: 03/04/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		3) DATE SURVEY COMPLETED
	34G336		B. WING _			03/03/2020
	NAME OF PROVIDER OR SUPPLIER FOREST HILLS GROUP HOME			STREET ADDRESS, CITY, STATE 1913 FOREST HILLS DRIVE GREENVILLE, NC 27858	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE	
E 004	CFR(s): 483.475(a) The [facility] must of Federal, State and preparedness requirements of this control of the facility of the seminorm of the facility of the	comply with all applicable local emergency irements. The [facility] must and maintain a comprehensive edness program that meets the		Preparation and exec Correction does not configure of agreement by the proof facts alleged or confinite statement of despection of the statement of despection of the statement of the statement of despective of federal and state land state lan	onstitute admi provider or the nclussion set for ficiencies. The red and/or exe quired by the	ssion truth orth e Plan ecuted
	and maintain an en that must be [review	n. The [facility] must develop nergency preparedness plan wed], and updated at least plan must do all of the				
	§485.625(a):] Emer CAH] must comply State, and local em requirements. The develop and mainta emergency prepare	482.15 and CAHs at regency Plan. The [hospital or with all applicable Federal, ergency preparedness [hospital or CAH] must ain a comprehensive edness program that meets the s section, utilizing an ch.			EIVED 6 2020 censure Sect	
	Plan. The LTC facil an emergency prep	s at §483.73(a):] Emergency ity must develop and maintain aredness plan that must be ted at least annually.				
ABOD	Plan. The ESRD far maintain an emerge must be [evaluated] years.	es at §494.62(a):] Emergency cility must develop and ency preparedness plan that], and updated at least every 2		TITLE		(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Contraction Residence of the Contraction of the	LE CONSTRUCTION		E SURVEY PLETED
		34G336	B. WING		03/	03/2020
	PROVIDER OR SUPPLIER HILLS GROUP HOM	E	1	STREET ADDRESS, CITY, STATE, ZIP CODE 913 FOREST HILLS DRIVE GREENVILLE, NC 27858		
(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 APPROVIDENCE)	DBE	(X5) COMPLETION DATE
E 004	Based on record in failed to ensure the (EP) plan was revie annually. The finding The facility's EP play updated at least an Review on 3/2/20 coctober 2018) reveinformation regarding reside at the facility facility and client's 2018. Additional rewill be reviewed an annual basis." Fur include evidence of Interview on 3/3/20 Disabilities Profess	s not met as evidenced by: eview and interview, the facility e Emergency Preparedmess ewed and updated at least ng is: an was not reviewed and/or	E 004	PD will update all resident inform the Emergency Plan (EP). PD will RDO to ensure plan is reviewed updated. Plan to prevent reoccurrance: PD will update the EP when there discharge/admission to ensure a resident information is filed in the PD will update plan as required a will review annually.	e is a ccurate plan.	
E 039	EP Testing Require CFR(s): 483.475(d) *[For RNCHI at §40 HHAs at §484.102, "Organizations" und §485.920, RHC/FQ Facilities at §494.62 (2) Testing. The [facto test the emerger must do all of the foculty (i) Participate in community-based expressions.	o(2) 03.748, ASCs at §416.54, CORFs at §485.68, OPO, der §485.727, CMHC at HC at §491.12, ESRD 2]: cility] must conduct exercises toy plan annually. The [facility] ollowing: a a full-scale exercise that is	E 039	PD inservice GHM and QP on the importance conducting tabletop of PD will file copies of exercises in Plan to prevent reoccurrance: PD will develop a schedule for tall exercises to be conducted and in closely to ensure compliance.	excercise the EP.	4/15/2020 es.

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		34G336	B. WING	B. WING		3/03/2020	
	PROVIDER OR SUPPLIER HILLS GROUP HOM	E		STREET ADDRESS, CITY, STATE, ZIP O 1913 FOREST HILLS DRIVE GREENVILLE, NC 27858			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 039	not accessible, con exercise every 2 (B) If the [finatural or man-mace is exempt from enging community-based of functional exercise this section is conditional exercise this section is conditional exercise (B) A mock (C) A tablet is led by a facilitation discussion using a clinically-relevance of problem state prepared questions emergency plan. (iii) Analyze maintain document exercises, and emerevise the [facility's] *[For Hospices at 4 (2) Testing for hospicationally. The hospicin community based enditionally. The hospicin community based enditionally. The hospicin is led by a facilitation of patient's home. The exercises to test the annually. The hospicin community based enditional	adduct a facility-based functional years; or acility] experiences an actual de emergency that requires nergency plan, the [facility] laging in its next required or individual, facility-based exercise following the onset of additional exercise at least osite the year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is llowing: and full-scale exercise that is or individual, facility-based or disaster drill; or top exercise or workshop that is and includes a group narrated, and ements, directed messages, or designed to challenge an extendity eyents, and emergency plan, as needed. 18.113(d):] Dices that provide care in the expense must do the following: a full-scale exercise that is emergency plan at least fice must do the following: a full-scale exercise that is	EO	39			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		TE SURVEY MPLETED	
	34G336		B. WING		03/03/2020		
	PROVIDER OR SUPPLIER HILLS GROUP HOMI	E		STREET ADDRESS, CITY, STATE ZIP CO 1913 FOREST HILLS DRIVE GREENVILLE, NC 27858			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
E 039	(B) If the hor man-made emer of the emergency pexempt from engage scale community-based the onset of the emergency pexempt from engage scale community-based the onset of the emergency pexempt from engages cale community-based the onset of the emergency opposite the functional exercise this section is conditional exercise this section is conditional exercise; or (B) A mock (C) A table is led by a facilitator discussion using a clinically-releval set of problem state prepared questions emergency plan. (3) Testing for hospicare directly. The hexercises to test the year. The hospice of the community-because of the community-because of the community-because of the confacility-based function (B) If the horizontal problem is the community-because of the confacility-based function (B) If the horizontal problem is the community-based function (B) If the community	duct an individual facility ercise every 2 years; or espice experiences a natural gency that requires activation lan, the hospital is ing in its next required full ased exercise or individual functional exercise following ergency event. additional exercise every 2 year the full-scale or under paragraph (d) (2)(i) of ucted, that may include, but is llowing: and full-scale exercise that is or a facility based functional disaster drill; or top exercise or workshop that and includes a group harrated, and emergency scenario, and a ements, directed messages, or designed to challenge an designed to challenge an dices that provide inpatient ospice must conduct emergency plan twice per must do the following: an annual full-scale exercise ased; or community-based exercise is duct an annual individual orapice experiences a natural gency that requires activation	E O	39			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDIN	IPLE CONSTRUCTION		COMPLETED	
		34G336	B. WING _		03	3/03/2020
NAME OF PROVIDER OR SUPPLIER FOREST HILLS GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 1913 FOREST HILLS DRIVE GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
E 039	exempt from engage full-scale community functional of the emergency e (ii) Conduct and that may include, but following: (A) A secon community-based of exercise; or (B) A mock (C) A table by a facilitator that using a narrated, emergency scenaristatements, directed questions desemble emergency plan. (iii) Analyze the maintain document exercises, and emergency plan. (iii) Analyze the maintain document exercises, and emergency plan. (For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [Preconduct exercises that is community-but (A) When a not accessible, confacility-based function (B) If the [Prexperiences an active emergency that required that is community-but experiences an active emergency that required that is experienced that is ex	sing in its next required by based or facility-based exercise following the onset exercise following the onset exercise following the onset exercise additional annual exercise and tis not limited to the find full-scale exercise that is or a facility based functional for a facility based functional full-scale facility based functional full-scale for a facility based functional full-scale functional functional full-scale functional full-scale functional full-scale functional functional full-	E 03			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G336		200.000M 2004.040.00	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING_		0:	03/03/2020	
	PROVIDER OR SUPPLIER	E		STREET ADDRESS. CITY, STATE. ZIP CODE 1913 FOREST HILLS DRIVE GREENVILLE, NC 27858		
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 039	engaging in its next based or functional exercise emergency event. (ii) Conduct an and that may include following: (A) A second community-based of functional exercise (B) A mode (C) A table is led by a facilitate discussion, using a clinically-relevate set of problem state prepared questions emergency plan. (iii) Analyze the maintain document exercises, and emergency plan exercises, and emergency plan exercises, and emergency procedulate (C) The [LTC facility test the emergency procedul (CF/IID) must do the (i) Participate in that is community-bused function (B) If the [Lan actual natural or requires activation of functional control of the	t required full-scale community individual, facility-based following the onset of the [additional] annual exercise or de, but is not limited to the ind full-scale exercise that is or individual, a facility-based; or a disaster drill; or top exercise or workshop that is an includes a group in narrated, and ements, directed messages, or designed to challenge an action of all drills, tabletop ergency events—and revise gency plan, as needed. at §483.73(d):] I) must conduct exercises to plan at least twice per year, inced staff drills using the ures. The [LTC facility, e following: in an annual full-scale exercise is duct an annual individual, onal—exercise. TC facility] facility experiences man-made emergency that	E 03	39		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		34G336	B. WING		03	/03/2020
	PROVIDER OR SUPPLIER HILLS GROUP HOM	Ε ,		STREET ADDRESS, CITY, STATE, ZIP CODE 1913 FOREST HILLS DRIVE GREENVILLE, NC 27858		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
E 039	required a full-scale individual, facili following the onset (ii) Conduct are that may include, be following: (A) A secon community-based of functional exercise (B) A mood (C) A table is led by a facilitate using a narrated, emergency scenaristatements, directed questions demergency plan. (iii) Analyze the response to and madrills, tabletop exercise emergency plan, as "[For ICF/IIDs at §4 (2) Testing. The ICF to test the emergency plan is community-but (A) When a not accessible, confacility-based function (B) If the IC natural or man-madactivation of the emis exempt from engul-scale community-scale community-scal	e community-based or ity-based functional exercise of the emergency event. In additional annual exercise ut is not limited to the utility based or an individual, facility based or it is not limited to the utility or etop exercise or workshop that it includes a group discussion, clinically-relevant or, and a set of problem of messages, or prepared signed to challenge an utility facility's anitain documentation of all cises, and emergency the [LTC facility] facility's in needed. 183.475(d)]: F/IID must conduct exercises or the following: In an annual full-scale exercise is duct an annual individual, onal exercise; or. 2F/IID experiences an actual de emergency that requires	E	039		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.					ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G336	B. WING			0:	3/03/2020
	PROVIDER OR SUPPLIER HILLS GROUP HOM	E		1913	FOREST HILLS DRIVE ENVILLE, NC 27858		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 039	of the emergency e (ii) Conduct an may include, but is (A) A secon community-based of functional exercise (B) A mock (C) A table is led by a facilitato discussion, using a clinically-releva set of problem state prepared questions emergency plan. (iii) Analyze the maintain document exercises, and eme the ICF/IID's emergency *[For OPOs at §486 (d)(2) Testing. The to test the emergency following: (i) Conduct a por workshop at lease is led by a facilitato discussion, using a emergency scenari statements, dire questions designed plan. If the OPO ex or man-made emer of the emergency p engaging in its next following the onset (ii) Analyze the maintain document	event. additional annual exercise that not limited to the following: and full-scale exercise that is or an individual, facility-based; or a disaster drill; or top exercise or workshop that is an and includes a group anarrated, ant emergency scenario, and a ements, directed messages, or designed to challenge an electron of all drills, tabletop ergency events, and revise gency plan, as needed. 6.360] OPO must conduct exercises and per-based, tabletop exercise annually. A tabletop exercise st annually. A tabletop exercise	E	039			

PRINTED: 03/04/2020 FORM APPROVED

		THE STORES			U	NIP INC	7. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		34G336	B. WING	2		03	/03/2020	
	PROVIDER OR SUPPLIER HILLS GROUP HOM	E		STREET ADDRESS, CITY, STATE, I 1913 FOREST HILLS DRIVE GREENVILLE, NC 27858	ZIP CODE		700/2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
E 039	and OPO's] emerg This STANDARD is Based on docume facility failed to ens or tabletop exercise emergency plan. T The facility's Emerg did not include comfacility/community-texercise.	ency plan, as needed, is not met as evidenced by: int review and interview, the sure a facility/community-based e was conducted to test their. The finding is: gency Preparedness (EP) plan inpletion of based exercise or tabletop	E 0	39				
	October 2018) did it community-based of exercise or a tablet emergency plan. Interview on 3/3/20 indicated the facility training with staff re	of the facility's EP plan (dated not include a full-scale or individual facility-based op exercise to test their with the Home Manager of has completed monthly egarding their EP plan;						
W 120	facility/community-be exercise to test the emergency plan.	not conducted a full-scale based exercise or a tabletop effectiveness of their current DED WITH OUTSIDE	W 12	20				
	The facility must as meet the needs of e	sure that outside services each client.						
	Based on record re	s not met as evidenced by: eview and interview, the facility side services met the needs of #1). The finding is:						

PRINTED: 03/04/2020 FORM APPROVED

STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO	0. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A BUILDIN	IPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		34G336	B. WING			
FORES	PROVIDER OR SUPPLIER THILLS GROUP HOM			STREET ADDRESS, CITY, STATE, ZIP O 1913 FOREST HILLS DRIVE GREENVILLE, NC 27858	CODE	/03/2020
PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	A copy of client #1's Plan (IPP) and Behanot available at the Review on 3/2/20 of individual program pehavior support plarevised 12/8/19. Interview on 3/2/20 of teacher revealed his provided to the school the teacher revealed invited to his IPP me Interview on 3/3/20 of disabilities profession	s current Individual Program avior Support Plan (BSP) was school. f client #1 record revealed an plan (IPP) dated 8/13/19 and a an (BSP) dated 7/13/19, with client #1's public school IPP and BSP had not been not by the facility. In addition, it that she has never been	W 126		ool teachers. note that the been shared so send written wite them to will file a individuals'	



March 16, 2020

Mental Health Licensure and Certification Section NC Division of Health Service Regulation 2718 Mail Service Center Raleigh, NC 27699-2718

Dear Mrs. Justin Foster:

Enclosed is the Plan of Correction for Forest Hill Group Home from the recertification survey completed on 3/3/2020. Please know that we are addressing all items cited during the survey. Please feel free to call me with any questions or concerns.

Sincerely,

Ms. Cynthia B. Stevens, BS, CESP

Program Director

RHA Health Services, LLC

1793 Briley Road

Greenville, North Carolina 27834

(252)-559-0016

cstevens@rhanet.org