	-	ID HUMAN SERVICES				FORM	APPROVED	
	5 FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391 (X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	ING_		COMF	PLETED	
34G114		B. WING			10/27/2020			
NAME OF PI	ROVIDER OR SUPPLIER	1	I	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
FOREST	CREEK GROUP HOME				5117 FOREST CREEK DRIVE			
				F	RALEIGH, NC 27606			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i)			262				
	The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.							
	This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the restrictive behavior support plan (BSP) for 2 of 3 audit clients (#2,#5) were reviewed and monitored by the human rights committee (HRC). The findings include:							
	A. Management staff failed to have the HRC review a restrictive behavior support plan (BSP) for client #2.							
	program plan (IPP) da has a BSP dated 9/1/ behavior of physical a this program revealed safety helmet, desens appointments a door locked linen closet. T the use of Luvox 100 appointments, Risper	of client #2's individual ated 8/12/20 revealed he 20 that addressed the target aggression. Further review of d it incorporates the use of a sitization plan for alarm, locked cabinet and his BSP also incorporated mg., Ativan 1mg. prior to dal 2mg. BID and Tegretol 00 mg. in the evening.						
	Review on 10/26/20 of BSP revealed it was r representative from th							
) with the Assistant vealed she could not locate committee approval for						

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

TITLE

(X6) DATE

PRINTED: 10/28/2020

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.

		D HUMAN SERVICES					FORM): 10/28/2020 1 APPROVED
CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		34G114	B. WING			10/27/2020		
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STAT	ΓΕ, ZIP CODE		
FOREST	REEK GROUP HOME				117 FOREST CREEK DRIVE ALEIGH, NC 27606	i		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 262	Continued From page 1 client #2's BSP.		w	W 262				
	B. Management staff approval for client #5'							
	2/8/20 revealed a BSI addressed the target property destruction, p inappropriate verbaliz incorporates the use of Trazedone 50mg., the	behavior of non-compliance, ohysical aggression ations. This program of Atarax 25 mg. and a use of a desensitization						
		evealed the consent for led it was not signed by a						
W 263	Interview on 10/26/20 Executive Director re- written HRC approval PROGRAM MONITO CFR(s): 483.440(f)(3)	vealed she could not locate for client #5's BSP. RING & CHANGE	w	263				
	are conducted only w	I insure that these programs th the written informed parents (if the client is a an.						
	Based on record revi failed to ensure client Support Plan (BSP) ir consent from their leg 1 of 3 audit clients (#2	cluded written informed al guardians. This affected						

Facility ID: 921876

If continuation sheet Page 2 of 5

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & M				FOR	M APPROVED 0. 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED			
	34G114	B. WING		10	/27/2020			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· ·				
FOREST CREEK GROUP HOME			5117 FOREST CREEK DRIVE RALEIGH, NC 27606					
PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE			
 consent from his legat Review on 10/26/20 or program plan (IPP) date was appointed a legal revealed he has a BS addressed the target he aggression. Further revealed it incorporate helmet, desensitization door alarm, locked cal closet. This BSP also Luvox 100 mg., Ativar appointments, Rispert 300 mg. in am and 10 Review on 10/26/20 or Consent form revealed informed consent from but only had the signat psychologist. Interview on 10/27/20 director and the prograws not written inform client #2. W 331 W 331 NURSING SERVICES CFR(s): 483.460(c) The facility must proviservices in accordance This STANDARD is m Based on record revisified to provide nursitiwith the needs of 1 of 	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 consent from his legal guardian. Review on 10/26/20 of client #2's individual program plan (IPP) dated 8/12/20 revealed he was appointed a legal guardian. Further review revealed he has a BSP dated 9/1/20 that addressed the target behavior of physical aggression. Further review of this program revealed it incorporates the use of a safety helmet, desensitization plan for appointments a door alarm, locked cabinet and locked linen closet. This BSP also incorporated the use of Luvox 100 mg., Ativan 1mg. prior to appointments, Risperdal 2mg. BID and Tegretol 300 mg. in am and 100 mg. in the evening. Review on 10/26/20 of the Behavior Program Consent form revealed there was not written informed consent from client #2's legal guardian but only had the signature of the facility psychologist. Interview on 10/27/20 with the assistant executive director and the program director revealed there was not written informed consent for the BSP for client #2. NURSING SERVICES		263					

If continuation sheet Page 3 of 5

PRINTED: 10/28/2020

		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 10/28/2020 APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) P		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G114	B. WING		_	10/2	27/2020
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
FOREST CREEK GROUP HOME				117 FOREST CREEK DRI ALEIGH, NC 27606	VE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 331	consent from the guar client #5. Review on 10/26/20 of client #5 dated 7/8/20 located on client #5's the physician was una ultrasound because of Will require surgery. Review of a nursing a report signed 7/8/20 of stable. Note mass L or require surgery." Review on 10/26/20 of 8/17/20 for client #5 of Mass-Needle biopsy remove tumor. Will dis Review on 10/26/20 of summary signed on 9 revealed " 8/17/20: F/ Mass-Recommend Fi Surgery to remove-W Review of the Nursing revealed no further no	The finding is: ed to follow the physician to obtain rdian for diagnostic tests for of a physician consult for prevealed a mass had been left parotid gland and that able to complete an lient #5 was uncooperative. Assessment and review revealed, " Overall health heck-U/S not completed. Will of physician consult dated evealed "Parotid and eventual surgery to scuss with guardian." of the Nursing monthly 0/6/20 by the facility nurse 'U on L Parotid ne needle Biopsy and ill Need to discuss POA." g notes on 10/26/20 otes about whether consent	W 331		DEFICIENCY)		
	whether the mass wa whether surgery was Interview by phone or nurse covering the fac	ent #5's guardian regarding s benign or malignant or to be scheduled. n 10/26/20 with the facility cility revealed she was ne disposition of client #5's					

Facility ID: 921876

If continuation sheet Page 4 of 5

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 10/28/2020 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		34G114	B. WING			10/27/2020	
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOME				5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 331	mass but that she wo office. Interview on 10/27/20 revealed there was no regarding whether the completed and what t confirmed it was not o	uld contact the physician's with the Program Manager o written documentation e needle biopsy had been the results were. He also clear whether the guardian o contacted for consent for a	W	331			

Facility ID: 921876

If continuation sheet Page 5 of 5