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

PRINTED: 10/28/2020
FORM APPROVED
OMB NO. 0938-0391

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 ______	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

(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 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) 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. Review on 10/26/20 of client #2's individual program plan (IPP) dated 8/12/20 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 consent for client #2's BSP revealed it was not signed by a representative from the HRC. Interview on 10/26/20 with the Assistant Executive Director revealed she could not locate written human rights committee approval for	W 262	W262 This deficiency will be corrected by the following actions: A. All behavioral support plans will be reviewed. B. All Behavioral Support Plans will be updated to address the current needs and technique to manager inappropriate behavior C. All proper techniques will be used to manage behaviors D. Psychologist will review all plans. E. Qualified Professional will review and obtain guardian consent. F. Qualified Professional will have consented BSP reviewed and signed by HRC representative G. All staff will be in-service on all Behavioral Support Plans and proper documentation. H. Residential Manager will monitor one time a week I. Qualified Professional will monitor one time a week	12.27.2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Marika Whack [signature]
TITLE: Executive Director
(X6) DATE: 11-1-2020

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.

RECEIVED
By DHSR Mental Health Licensure & Certification at 8:04 am, Nov 02, 2020

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W 262	Continued From page 1 client #2's BSP. B. Management staff failed to obtain HRC approval for client #5's restrictive BSP. Review on 10/26/20 of client #5's IPP dated 2/8/20 revealed a BSP dated 4/9/20 that addressed the target behavior of non-compliance, property destruction, physical aggression inappropriate verbalizations. This program incorporates the use of Atarax 25 mg. and Trazedone 50mg., the use of a desensitization program and a locked cabinet. Review on 10/26/20 revealed the consent for client #5's BSP revealed it was not signed by a representative from the HRC. Interview on 10/26/20 with the Assistant Executive Director revealed she could not locate written HRC approval for client #5's BSP.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure client's restrictive Behavior Support Plan (BSP) included written informed consent from their legal guardians. This affected 1 of 3 audit clients (#2). The findings are: Client #2's BSP did not include written informed	W 263		

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W 263	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.	W 263	W.263 This deficiency will be corrected by the following actions: A. All behavioral support plans will be reviewed. B. All Behavioral Support Plans will be updated to address the current needs and technique to manager inappropriate behavior C. All proper techniques will be used to manage behaviors D. Psychologist will review all plans. E. Qualified Professional will review and obtain informed guardian consent for all plans before implementation F. All staff will be in-service on all Behavioral Support Plans and proper documentation. G. Site Supervisor will monitor one time a week H. Qualified Professional will monitor one time a week	12.27.2020
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 record review and interview, the facility failed to provide nursing services in accordance with the needs of 1 of 3 audit clients (#5) relative to following recommendations by the physician.	W 331		

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W 331	Continued From page 3 for diagnostic tests. The finding is: Nursing Services failed to follow recommendations by the physician to obtain consent from the guardian for diagnostic tests for client #5. Review on 10/26/20 of a physician consult for client #5 dated 7/8/20 revealed a mass had been located on client #5's left parotid gland and that the physician was unable to complete an ultrasound because client #5 was uncooperative. Will require surgery. Review of a nursing assessment and review report signed 7/8/20 revealed, " Overall health stable. Note mass L neck-U/S not completed. Will require surgery." Review on 10/26/20 of physician consult dated 8/17/20 for client #5 revealed "Parotid Mass-Needle biopsy and eventual surgery to remove tumor. Will discuss with guardian." Review on 10/26/20 of the Nursing monthly summary signed on 9/6/20 by the facility nurse revealed " 8/17/20: F/U on L Parotid Mass-Recommend Fine needle Biopsy and Surgery to remove-Will Need to discuss POA." Review of the Nursing notes on 10/26/20 revealed no further notes about whether consent was obtained from client #5's guardian regarding whether the mass was benign or malignant or whether surgery was to be scheduled. Interview by phone on 10/26/20 with the facility nurse covering the facility revealed she was uncertain regarding the disposition of client #5's	W 331	W.331 This deficiency will be corrected by the following actions: A. The facility will provide obtain and maintain preventive general medical care B. All medical appointment will be reviewed. C. The team will ensure appointments are schedule and follow up . D. All the appointments will be reviewed and discussed at the monthly core team/quarterlies/annual ISP. E. All physician orders will be reviewed, and all annual health screenings will be completed with supporting documentation if unable to complete/obtain/referred, the team will assess options with guardian. F. Qualified Professional will consult the guardian of all medical needs and to obtain consent for treatment. G. RN will review monthly H. Site Supervisor will monitor one time a week. I. Qualified Professional will monitor one time a week	12.27.2020

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W 331	Continued From page 4 mass but that she would contact the physician's office. Interview on 10/27/20 with the Program Manager revealed there was no written documentation regarding whether the needle biopsy had been completed and what the results were. He also confirmed it was not clear whether the guardian for client #5 had been contacted for consent for a recommended surgical procedure.	W 331		

11-01-'20 08:29 FROM- T-280 P0001/0007 F-725

Community Alternatives – NC
Southeast Region
1001 Navaho Drive Suite 101
Raleigh, NC 27609
Phone: 984-205-2630
FAX: 984-205-2643

RECEIVED
By DHSR Mental Health Licensure & Certification at 8:03 am, Nov 02, 2020

FAX

To:	Kim McCaskill	From:	Jermaine Keung
Fax:	919.715.8078	Pages:	6
Phone:	919.855-3795	Date:	11.1.2020
Re:	Survey	CC:	

☐ Urgent ☐ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments: Thank You

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November 1, 2020

Kimberly C. MCCaskill, MSW
Facility Compliance Consultant I
Mental Health Licensure and Certification section
NC Division of Health Services Regulations
2718 Mail Service Center
Raleigh NC 27699-2718
919.855.3795 office
919.715.8078 fax

RE: Plan of Correction for Annual Survey Completed October 27, 2020
Forest Creek Group Home,
5117 Forest Creek Drive, Raleigh, NC 27606
Provider Number : 34G114
MHL# 092-044

Dear Ms. McCaskill

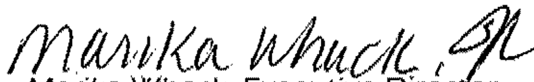
We appreciate the courtesy extended by you while surveying the **Forest Creek Group Home,** Raleigh ,North Carolina.

As indicated on the Plan of Correction, we will have the Deficiencies corrected for, the Annual survey completed on October 13, 2020 completed **December 27, 2020**

We are committed to providing the highest possible care for the people we serve at **Forest Creek Group Home,.**

If you have questions, please contact Cynthia Bradford, Assistant Executive Director 276.252.8193 cell 984.205.2630 ext. 238. Or JerMaine Kearney, Program Manager 984.205.2630 ext 403

Sincerely,



Marika Whack, Executive Director
Community Alternatives North Carolina- Southeast Region
1001 Navaho Drive suite 101
Raleigh, North Carolina, 27609
919.827.2790 cell
984.205.2630 etx. 405
mawhack@rescare.com