	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		34G133	B. WING _			05/	06/2021
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST E	BEND GROUP HOME				7 S OAK STREET REVARD, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 217	INDIVIDUAL PROGR CFR(s): 483.440(c)(3		W 2	217			
	The comprehensive for include nutritional sta	unctional assessment must tus.					
	Based on record revi facility failed to compl	not met as evidenced by: iew and interviews, the lete a nutritional assessment dmission for 2 of 3 sampled The finding is:					
		to complete a nutritional nission for client #5. For					
	5/5-5/6/21 survey rev in meals with other re Observation during m	roup home during the ealed client #5 to participate esidents of the group home. heals of the place setting for e client to use a plate guard.					
	5/6/21 revealed an ac Continued review of r a person centered pla record review reveale conducted 9/16/20 wi at meals. Review of r 9/2020 swallow study mechanical soft (grou	or client #5 conducted on dmission date of 2/28/20. ecords for client #5 revealed an dated 3/25/21. Further ed a swallow study was th client #5 due to coughing recommendations from the r revealed solid foods to be and)/pureed; moisten all					
	applesauce. Further from the current swall was to remain upright swallow 2 x for each I pocketing and alterna	ption, thin liquids and m should be embed in review of recommendations low study revealed the client t 60 minutes after eating, bite/sip, check mouth for te solids and liquids always quid. Additional review of					

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

TITLE

(X6) DATE

PRINTED: 05/16/2021

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	): 05/16/2021 MAPPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 093 (X3) DATE SURVE COMPLETED	
		34G133	B. WING _			_	05/	06/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
FOREST BEND GROUP HOME					7 S OAK STREET REVARD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	(	(EACH CORRE) CROSS-REFEREI	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 217	records revealed a nu been completed for cl survey date, 14 month An interview conducted 5/6/21 confirmed the in for client #5 had not be current survey date. Of facility nurse verified of coughing at meals that study. Further intervier revealed the recent he attributed to the reason a nutritional assessme B. The facility failed the assessment after adme example: Observations in the g 5/5-5/6/21 survey reve in meals with other re Observation during m client #4 revealed the and built up utensils. A review of records fo 5/6/21 revealed an ad Further review of the a person centered plat review of the record re evaluation had not be as of the current surve admission. An interview conducted 5/6/21 confirmed the interview of the record re- son centered plater and the interview conducted so for the current surve admission.	tritional evaluation had not ient #5 as of the current hs after admission. Ad with the facility nurse on initial nutritional assessment been completed as of the Continued interview with the client #5 had experienced at resulted in a swallow ew with the facility nurse ealth pandemic was on for the delay in obtaining ent for client #5. o complete a nutritional hission for client #4. For roup home during the ealed client #4 to participate sidents of the group home. eals of the place setting for client to use a plate guard or client #4 conducted on fmission date of 2/28/20. record for client #4 revealed an dated 3/25/21. Further	W 2	.17				

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		MEDICAID SERVICES				0938-039		
	ATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         D PLAN OF CORRECTION       IDENTIFICATION NUMBER:		· ,			(X3) DATE SURVEY COMPLETED		
		34G133	B. WING		05/	06/2021		
NAME OF P	ROVIDER OR SUPPLIER	·	STI	REET ADDRESS, CITY, STATE, ZIP COD	E			
FOREST	BEND GROUP HOME			S OAK STREET REVARD, NC 28712				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE		
W 217	current survey date. I facility nurse revealed was attributed to the	e 2 Further interview with the d the recent health pandemic reason for the delay in I assessment for client #4.	W 217					
W 227	INDIVIDUAL PROGR CFR(s): 483.440(c)(4		W 227					
	objectives necessary as identified by the co	m plan states the specific to meet the client's needs, omprehensive assessment h (c)(3) of this section.						
	Based on observatio interview, the person to have sufficient guid identified client needs	not met as evidenced by: n, review of records and centered plan (PCP) failed delines or training to meet s relative to safe swallowing ents (#5). The finding is:						
	5/5-5/6/21 survey rev in meals with other re Observation during m	roup home during the realed client #5 to participate esidents of the group home. neals of the place setting for e client to use a plate guard.						
	5/6/21 revealed an ac Continued review of t revealed a person ce Additional record revi	or client #5 conducted on dmission date of 2/28/20. the record for client #5 ntered plan dated 3/25/21. ew revealed a swallow study						
	coughing at meals. F from the 9/2020 swal foods to be mechanic	20 with client #5 due to Review of recommendations low study revealed solid cal soft (ground)/pureed; ore consumption, thin liquids						

Facility ID: 921875

If continuation sheet Page 3 of 9

F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION			
LAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	G	(X3) DATE SURVEY COMPLETED		
	34G133	B. WING		05	5/06/2021	
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
END GROUP HOME			47 S OAK STREET BREVARD, NC 28712			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETIO DATE	
Continued From page	e 3	W 22	27			
ending with a sip of lie	quid.					
An interview conduct	ed with the facility nurse on					
	•					
coughing at meals that	at resulted in a swallow					
•	-					
-						
recommendations. F	urther interview with the					
		W 24	17			
The individual progra	m plan must include					
opportunities for clien						
	act mat as suideneed by:					
plans (PCPs) for 2 of	3 sampled clients (#4 and					
	END GROUP HOME SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page applesauce. Further from the current swal was to remain uprigh swallow 2 x for each pocketing and alterna ending with a sip of lif An interview conducts 5/6/21 confirmed client coughing at meals that study. Continued inter revealed she was unser receiving medications recommendations. F facility nurse and the disabilities profession or training objectives recommendations of had not been implem with the facility nurse should have formal g recommendations of study. INDIVIDUAL PROGR CFR(s): 483.440(c)(6 The individual prografic opportunities for client self-management. This STANDARD is no The facility failed to a plans (PCPs) for 2 of #5) included opportung dining as evidenced b	END GROUP HOME SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 applesauce. Further review of recommendations from the current swallow study revealed the client was to remain upright 60 minutes after eating, swallow 2 x for each bite/sip, check mouth for pocketing and alternate solids and liquids always ending with a sip of liquid. An interview conducted with the facility nurse on 5/6/21 confirmed client #5 had experienced coughing at meals that resulted in a swallow study. Continued interview with the facility nurse revealed she was unsure if client #5 was receiving medications in applesauce as recommended in the swallow study recommendations. Further interview with the facility nurse and the facility qualified intellectual disabilities professional (QIDP) verified guidelines or training objectives relative to the recommendations of client #5's swallow study had not been implemented. Additional interview with the facility nurse and QIDP verified client #5 should have formal guidelines to address the recommendations of the client's current swallow study. INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi) The individual program plan must include opportunities for client choice and	END GROUP HOME       ID         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID         Continued From page 3       W 22         applesauce. Further review of recommendations from the current swallow study revealed the client was to remain upright 60 minutes after eating, swallow 2 x for each bite/sip, check mouth for pocketing and alternate solids and liquids always ending with a sip of liquid.       W 22         An interview conducted with the facility nurse on 5/6/21 confirmed client #5 had experienced coughing at meals that resulted in a swallow study. Continued interview with the facility nurse revealed she was unsure if client #5 was receiving medications in applesauce as recommendations. Further interview with the facility nurse and the facility qualified intellectual disabilities professional (QIDP) verified guidelines or training objectives relative to the recommendations of client #5's swallow study had not been implemented. Additional interview with the facility nurse and QIDP verified client #5 should have formal guidelines to address the recommendations of the client's current swallow study.       W 24         INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi)       W 24         The individual program plan must include opportunities for client choice and self-management.       W 24         This STANDARD is not met as evidenced by: The facility failed to assure the person centered plans (PCPs) for 2 of 3 sampled clients (#4 and #5) included opportunities for choice and self-management regarding meal preparation and dining as evidenced by observation, interview and	END GROUP HOME       47 S OAK STREET BREVARD, NC. 28712         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PROVIDENCE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY         Continued From page 3 applesauce. Further review of recommendations from the current swallow study revealed the client was to remain upright 60 minutes after eating, swallow 2 x for each bite/sip, check mouth for pocketing and alternate solids and liquids always ending with a sip of liquid.       W 227         An interview conducted with the facility nurse on 5/6/21 confirmed client #5 had experienced coughing at meals that resulted in a swallow study. Continued interview with the facility nurse revealed she was unsure if client #5 was receiving medications in applesauce as recommendations of client #5's swallow study trecommendations of the client #5's swallow study had not been implemented. Additional interview with the facility nurse and 0LDP verified guidelines or training objectives relative to the recommendations of the client's swallow study.       W 247         INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(vi)       W 247         The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: The facility failed to assure the person centered plans (PCFP) for 2 of 3 sampled clients (#4 and #5) included opportunities for choice and self-management regarding meal preparation and dining as evidenced by observation, interview and	END GROUP HOME         47 S OAK STREET BREVARD, NC 23712           Isoumary stratement of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIEED BY FULL REDUATORY OR LSE DENTIFYING INFORMATION)         IP         PRECIENCY TAG         PRECIENCY CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD BE CROSS-REFERENCE ACTION SHOULD ACTION SHOULD SHOULD SHOULD SHOULD SHOULD BE CROSS-REFERENCE ACTION SHOULD SH	

Event ID: TMT011

Facility ID: 921875

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/16/2021 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE SUR COMPLETE	
		34G133	B. WING		_	05/0	06/2021
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
FOREST BEND GROUP HOME				47 S OAK STREET BREVARD, NC 28712			
(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 BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 247	Afternoon observation 5/5/21 revealed staff I preparation at 4:30 Pl complete all aspects of without any client ass of the meal, staff was plates and to spoon c various client cups an was further observed ground menu items for Morning observations revealed staff to again breakfast preparation Staff was further observed to ground menu items Further observations the only participation #2 to assist with table for each client to put t utensils in the dishwa Review of records for PCPs both dated 3/28 client #4 revealed an dated 2/9/21 with inde selection of correct fla Continued review of c partial independence electric can opener, th cups/spoons and stor Review of the PCP fo adaptive behavior invi independent skills rela- utensils for spreading #5's ABI revealed par	hs in the group home on beginning supper M. Staff were observed to of supper preparation istance. Besides cooking all noted to set out the clients' hocolate powder into d serving containers. Staff to use the processor to or client #5. of breakfast on 5/6/21 n complete all cooking and without client participation. erved to use the processor a for client #5. after both meals revealed by the clients was for client setting at each meal and heir plates, cups and sher after each meal. client #4 and #5 revealed 5/21. Review of the PCP for adaptive behavior inventory ependent skills related to the atware and dishes. dient #4's ABI revealed skills with the use of an ne use of measuring	W 243	7			

Facility ID: 921875

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/16/2021 APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G133	B. WING		_	05/0	06/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
FOREST BEND GROUP HOME				F7 S OAK STREET BREVARD, NC 28712			
(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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 247 W 436	records for client's #4 objective training in the linterview with the fact disabilities profession should be offered the meal preparation to the Continued interview w #5 would be capable staff supervision and items. Further intervit client #4 and #5 would objectives to address SPACE AND EQUIPM CFR(s): 483.470(g)(2) The facility must furni and teach clients to u choices about the use hearing and other cor and other devices ide interdisciplinary team	ns. Subsequent review of and #5 revealed no be area of meal preparation. Sility qualified intellectual al (QIDP) revealed clients opportunity to participate in be extent they are capable. With the QIDP verified client of using a processor with guidance to ground meal ew with the QIDP verified d benefit from training meal preparation. MENT ) sh, maintain in good repair, se and to make informed e of dentures, eyeglasses, nmunications aids, braces, ntified by the as needed by the client. not met as evidenced by: n, record review and ailed to provide teaching e for 2 of 3 sampled clients ing is:	W 247		DEFICIENCY)		
	Observation in the gro revealed client #4 to p						

Facility ID: 921875

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	-	D HUMAN SERVICES				FORM	: 05/16/2021 APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES           STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		34G133	B. WING		_	05/0	06/2021
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
FOREST BEND GROUP HOME				Y S OAK STREET REVARD, NC 28712			
(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 BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 436	activities such as leise in his bedroom, to exe the group home utilizi for the dinner meal ar meal. Observation in revealed client #4 to p television in his bedro room for administration watch television in the hands and to participa Additional observation survey revealed at no glasses. Review of records for a person centered pla Review of the PCP fo equipment to include of records for client #4 dated 2/19/21. Revie revealed presenting s when watching televis compound hyopia, an review of the current y revealed prescribed g frequency. Interview with the faci 5/6/21 verified client # that the client keeps in to wear most of the tir nurse on 5/6/21 verified consult. Continued in nurse verified client # encouraged to wear h Interview with the qua professional (QIDP) v	ure with watching television ercise with walking around ing a walker, to wash hands ad to participate in the dinner the facility on 5/6/21 participate in watching iom, to enter the medication on of morning medications, a living room, to wash his ate in the breakfast meal. In during the 5/5-5/6/21 time for client #4 to wear client #4 on 5/6/21 revealed in (PCP) dated 3/25/21. r client #4 revealed adaptive glasses. Continued review 4 revealed a vision consult ymptoms of blurry vision sion and a diagnosis of d cataracts. Continued vision consult for client #4 lasses with continual lity home manager (HM) on t4 has prescribed glasses in his room and does not like me. Interview with the facility ed client #4 has glasses for ed in the current vision terview with the facility	W 436				

Facility ID: 921875

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	): 05/16/2021 APPROVED ). 0938-0391
STATEMENT C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SUR COMPLETE	
		34G133	B. WING _			_	05/	06/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
FOREST BEND GROUP HOME					S OAK STREET REVARD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 436	Continued From page the use and wear of h B. The facility failed to eyeglasses for client a Observation in the gro revealed client #5 to p activities such as leist in his bedroom, to pla staff, to wash hands f participate in the dinn facility on 5/6/21 reve in watching television on glasses while sittir Continued observatio #5 to remove his glas walk to the medication morning medications. revealed client #5 to p and the breakfast mea Review of records for a person centered pla Continued review of r a vision consult dated 2/2021 vision consult hyperopia, cataracts a Continued review of t	e 7 his eyeglasses. o provide teaching relative to #5. For example: oup home on 5/5/21 participate in various ure with watching television y a checkers game with or the dinner meal and to er meal. Observation in the aled client #5 to participate in his bedroom and to put ng in his bedroom. n at 8:42 AM revealed client ses and exit his room and n room for administration of Further observation participate in handwashing	W 4	.36				
	client #5 has prescrib in his room and does time. Interview with th verified client #5 has identified in the curren	lity HM on 5/6/21 verified ed glasses the client keeps not like to wear most of the facility nurse on 5/6/21 glasses for vision deficits nt vision consult. Continued lity nurse verified client #5 couraged to wear his						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 05/16/2021 APPROVED . 0938-0391
STATEMENT (	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		34G133	B. WING _			05/0	06/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
FOREST E	BEND GROUP HOME			47 S OAK STREET BREVARD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	IX (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE INCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 436	glasses as prescribed on 5/6/21 verified clie	<ol> <li>Interview with the QIDP nt #5 did not have a current aining relative to the use</li> </ol>	W 4				

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