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 _____	01/05/2022

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
E 030	Names and Contact Information CFR(s): 483.475(c)(1) §403.748(c)(1), §416.54(c)(1), §418.113(c)(1), §441.184(c)(1), §460.84(c)(1), §482.15(c)(1), §483.73(c)(1), §483.475(c)(1), §484.102(c)(1), §485.68(c)(1), §485.625(c)(1), §485.727(c)(1), §485.920(c)(1), §486.360(c)(1), §491.12(c)(1), §494.62(c)(1). [(c) The [facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For Hospitals at §482.15(c) and CAHs at §485.625(c)] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [hospitals and CAHs]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following:	E 030		

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

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E 030	Continued From page 1 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For HHAs at §484.102(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For OPOs at §486.360(c):] The communication plan must include all of the following:	E 030		

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E 030	Continued From page 2 (2) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This STANDARD is not met as evidenced by: Based on document review and interview, the facility failed to ensure an emergency preparedness (EP) communication plan was developed and maintained in compliance with Federal, State and local laws. The finding is: Review on 1/5/22 of the facility's EP plan did not include a face sheet for client #3 who was admitted to the facility on 3/22/21. During an interview on 1/5/22, the qualified intellectual disabilities professional (QIDP) confirmed the EP Plan did not have a face sheet for client #3.	E 030		
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 2 of 5 audit clients (#1 and #2) had the right to appropriate fitting clothing. The findings are: A. During observations in the home on 1/4/22 from 4:04pm until 5:55pm, client #2's pants where	W 137		

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W 137	Continued From page 3 observed hanging low on his hips. Further observations revealed client #2's buttocks was visible when he was bending over in the kitchen while assisting with meal preparation. Additional observations revealed client #1 was in the kitchen with a staff person and was never prompted to pull up or change his pants. Review on 1/5/22 of client #2's Community/Home Life Assessment dated 8/1/20 revealed he is totally independent with all aspects of dressing. During an interview on 1/4/22, the Site Manager (SM) confirmed client #2 can independently dress himself. B. During morning observations in the home on 1/5/22, client #1's pants where observed hanging low on his hips. Further observations revealed client #1 adult protective brief was visible. At no time was client #1 prompted to pull up his pants. Review on 1/5/22 of client #1's chart revealed he does not have a Community/Home Life Assessment. During an interview on 1/5/22, the SM revealed client #1 needs assistance with dressing from staff. During an interview on 1/5/22, the QIDP revealed client #2 is independent with dressing. Further interview revealed client #1 needs assistance from staff while dressing.	W 137		
W 213	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(ii) The comprehensive functional assessment must	W 213		

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W 213	Continued From page 4 identify the client's specific developmental strengths. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 5 audit clients (#1) Home/Life Skills Assessment had been done. The finding is: Review on 1/5/22 of client #1's individual program plan (IPP) dated 8/12/21 revealed he was admitted to the facility on 8/8/97. Further review revealed client #1 does not have a Home/Life Skills Assessment. During an interview on 1/5/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 did not have a current Home/Life Skills Assessment.	W 213		
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 restrictive programs were conducted with the written informed consent of a legal guardian. This affected 3 of 5 audit clients (#3, #4 and #5). The findings are: A. Review on 1/4/22 of client #3's behavior support plan (BSP) dated 5/20/21 revealed there was no signed consent by the guardian. Further review revealed client #1's behavior medications are Clozapine and Tetrabenazin.	W 263		

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W 263	Continued From page 5 B. Review on 1/4/22 of client #4's BSP dated 6/4/21 revealed there was no signed consent by the guardian. Further review revealed client #4's behavior medications are Buspar, Melatonin and Zyprexa. C. Review on 1/4/22 of client #5's BSP dated 6/4/21 revealed there was no signed consent by the guardian. Further review revealed client #5's behavior medications are Abilify, Zoloft and Zyprexa. During an interview on 1/5/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed clients #3, #4 and #5 records did not include updated BSP consents, which were signed and dated by their guardians.	W 263		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a technique to address the inappropriate behaviors of 1 of 5 audit clients (#1) was included in a active treatment plan. The finding is: During evening observations in the home on 1/4/22, Staff A used a key to unlock the pantry door, so a client could go inside and retrieve some food items. Further observations revealed there was also a lock on the side by side refrigerator.	W 288		

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W 288	Continued From page 6 During an interview on 1/4/22, Staff A revealed the pantry and the refrigerator are kept locked due to a former client, who no longer lives in the home, because he would steal food. Further interview revealed client #1 will also attempt to steal food. Staff A stated the locked pantry and refrigerator information should be in client #1's chart and the other four clients residing in the home. Review on 1/4/22 of client #1's chart did not reveal any information concerning the locked pantry and refrigerator. During an interview on 1/4/22, the Site Manager (SM) revealed there was not a consent in client #1's chart in reference to keeping the pantry and refrigerator locked. Further interview confirmed there where no consents in the other four clients charts. During an interview on 1/5/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed client #1 does not have a consent for the locked pantry and refrigerator. The QIDP also stated the other four clients do not have consents either.	W 288		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, documentation and	W 340		

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W 340	Continued From page 7 interview, nursing services failed to ensure that staff were sufficiently trained in the proper wearing of face masks. This potentially effected all clients (#1, #2, #3, #4 and #5) residing in the facility. The finding is: During observations in the home on 1/4/22 from 4:20pm until 5:45pm, Staff A was observed not wearing a face mask. Further observations revealed Staff A was in the kitchen doing meal preparation with a client. Additional observations revealed the Site Manager (SM) looking directly at Staff A and talking with him. Review on 1/4/22 of a memorandum located on a bulletin board at the homes' entrance stated, "Please wear a mask when inside." During an interview on 1/4/22, Staff A stated face masks should be worn at all times while staff are on shift in the home. During an interview on 1/4/22, the SM confirmed staff are to wear a face mask at all times while they are working in the home. During an interview on 1/5/22, the Qualified Intellectual Disabilities Professional (QIDP) revealed staff are to wear a face mask while they are inside the home.	W 340		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observations, record review and staff	W 369		

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W 369	Continued From page 8 interviews, the facility failed to ensure medications were administered without error for 1 of 5 clients (#4) observed during the administration of medications. The finding is: During medication administration observations in the home on 1/4/22 at 4:31pm, client #4 consumed four pills. During further observation of the pill bubble packs, the surveyor noticed one of the pill bubble packs had the name of another client. During an immediate interview, Staff B, who was the medication technician, revealed she did not look at the names on the pill bubble packs, even though staff are trained to do so. During an interview on 1/4/22, the Site Manager (SM) stated staff have been trained to ensure they follow the following: name, route, medication and time. During an interview on 1/5/22, the Qualified Intellectual Disabilities Professional (QIDP) confirmed all medications should be thoroughly checked prior to being given.	W 369		