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

PRINTED: 09/16/2021
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
	34G336	A. BUILDING _____ B. WING _____	09/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST HILLS GROUP HOME	1913 FOREST HILLS DRIVE GREENVILLE, NC 27858

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W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure outside services meet the needs of each client. This affected 2 of 4 audit clients (#1 and #6). The finding is: A. Review on 9/13/21 of client #6's record revealed an Individual Program Plan (IPP) dated 2/17/21 and a Behavior Support Plan (BSP) dated 1/22/21. The plan indicated the client is 14 years old and attends a local high school. Interview on 9/13/21 with Teacher B revealed he was not aware client #6 had a BSP or IPP and does not have a copy of these documents. Additional interview indicated he would like to have a copy of the client's IPP and BSP in order to be consistent with implementation of objectives identified by the group home. Interview on 9/14/21 with the Program Director (PD) revealed copies of client #6's IPP and BSP were taken to his school at the beginning of the school year and given to someone in the administration office. Additional interview indicated she could not be sure if the teacher received the documents from the office. B. Review on 9/13/21 of client #1's record revealed an IPP dated 12/9/20 and a BSP dated 11/4/20 with an addendum on 7/21/21. The plan indicated the client is 12 years old and attends	W 120	Preparation and execution of this Plan of Correction does not constitute admission of agreement by the provider or the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law. W120 QP will provide copies of residents' Behavior Support Plans and Person Centered Plans to all teachers and will routinely provide copies as documents are modifies or ammended. 11/12/21 QP will develop a signature page for teachers to sign upon receipt of documents and file in each resident's chart. GHM will review residents' daily communication book, sign and respond to teachers' request in a timely manner. Plan to prevent re-occurrence: Monitoring will be conducted by the PD for the next six months to ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia B. Stevens Cynthia B. Stevens	Program Director	9/21/2021

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.

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W 120	Continued From page 1 middle school. Interview on 9/13/21 with Teacher A revealed she was not aware client #1 had a BSP or IPP and does not have a copy of these documents. Additional interview indicated she would like to have a copy of the client's IPP and BSP in order to be consistent with implementation of objectives identified by the group home. Teacher A revealed that the former Home Manager (HM) was the contact person with the school. The teacher's expectation was for the HM to review daily communications from the school and respond to requests so that supports can be coordinated in a timely manner. Interview on 9/14/21 with the PD revealed copies of client #1's IPP and BSP were taken to his school at the beginning of the school year and given to someone in the administration office. Additional interview indicated she could not be sure if the teacher received the documents from the office. The PD stated that she would ensure that the new HM responded to future requests communicated through client #1's school planner.	W 120		
W 227	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(4) The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to ensure 2 of 4	W 227	W227 QP will work with HS to develop goal to formally address shoetying for client #1. HS will in-service staff on the shoetying objective and will initiate the formal training of the objective. QP will work with HS to develop a formal objective to address Client #1's regression with bowel elimination. HS will in service staff on the toileting objective and will initiate the formal training of the objective.	11/12/21

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W 227	Continued From page 2 audit clients (#1 and #2) individual program plans (IPP) included training objectives to meet client's needs in the areas of tying shoelaces, eliminating toileting accidents and developing language skills. The findings are: A. During observations in the home on 9/13/21 at 5:00 PM, the Home Manager (HM) noticed that client #1 had long untied shoelaces and told him to tie his shoes. Client #1 sat down on the sofa and attempted to tie his shoelaces but did not know how. When the HM re-entered the room, client #1 asked for help with his shoes. The HM tied the shoelaces of client #1. Review on 9/13/21 of the IPP for client #1 dated 12/9/20 revealed there was an undated handwritten inserted note that read; "OT (occupational therapist) would like client #1 to work on independence in shoe tying..." An additional review on 9/14/21 of the Adaptive Behavior Inventory (ABI) dated 3/29/21 revealed that client #1 was not independent with shoelace tying. Review on 9/14/21 of the OT Initial Evaluation dated 2/16/21 revealed that client #1 was limited in adaptive daily living (ADL) independence with shoe tying. A short term goal of 6 months, to be independent with shoe tying. An interview on 9/13/21 with Teacher A at client #1's school revealed that he could not tie his shoelaces, was "clumsy" and has fallen over them. She recommended that he work on a shoelace tying goal at home and wear a velcro fastened shoes to school. An interview on 9/14/21 with the Program Director	W 227	W227 Con't: PD requested a copy of Client #2 s Speech Language Pathology (SLP) evaluation. PD, QP and GHM reviewed the evaluation. QP added recommendation to Client #2's PCP and reached out the SLP provider to initiate sessions. Plan to prevent re-occurrence: QP will work closely with the HS to ensure formal objectives are developped to address recommendations. QP will thoroughly review all evaluations upon receipt and facilitate a core meeting to discuss and address recommendations. QP will document the core team meeting Monitoring will be conducted monthly for the next six months to ensure by the QP, FD and QA to ensure compliance.	

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W 227	Continued From page 3 (PD) revealed that the previous Habilitation Specialist (HS) was let go in January and it took until March 2021, before that position was replaced. The PD's expectation was for the HS to review the evaluation and be responsible for the training. The PD acknowledged that ultimately she was responsible for making sure it was done. B. Review on 9/14/21 of the client #1's ABI dated 3/29/21 revealed that he was totally independent with toileting procedures and could self initiate. Client #1's toileting skills were independent for daytime, night time and trips. An additional review of the Annual Nursing Evaluation dated 12/8/20 revealed that client #1 was continent of bowel. Review on 9/13/21 of the Mini Team Report dated 7/19/21 revealed that client #1 had began attention seeking behavior with bowel elimination and had regressed. An interview on 9/13/21 with Teacher A revealed that client #1 does not have a change of clothes for the toileting accidents he had at school. Teacher A questioned if client #1 was on a toilet schedule at home. An interview on 9/14/21 with the Qualified Intellectual Disabilities Professional (QIDP) revealed that she started her position in July, 2021 and was present at the Mini Team Meeting. She acknowledged that a training program to address client #1's regression with bowel elimination had not been developed. C. Review on 9/14/21 of client #2's IPP dated 6/16/21 revealed no information regarding client #2's specific treatments for staff use to support his language skills development.	W 227		

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W 227	Continued From page 4 Review on 9/15/21, upon receipt of client #2's Speech Language Pathology (SLP) Initial Examination dated 7/12/21 identified that client #2 had profound receptive/expressive language delays. Instructions were written for 12 weeks of short term goals and 12 weeks of long term goals to increase client #2's functional communication skills in order to express his wants and needs to caregivers around him. Interview on 9/14/21 with the Home Manager (HM), QIDP and PD confirmed client #2's IPP did not include any information to address his speech language delays. The PD stated that an evaluation had been done after his admission on an unknown date and she would need to request a copy of it. The HM, QIDP and PD acknowledged that they have not reviewed the evaluation and did not know if there were treatment recommendations.	W 227		
W 240	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(6)(i) The individual program plan must describe relevant interventions to support the individual toward independence. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure clients Individual Program Plan (IPP) included specific information to support client #6 with wearing his eyeglasses and to address his excessive drooling. This affected 1 of 4 audit clients (#6). The findings are:	W 240	W240 QP updated Client #6's PCP to include the use of eye glasses and the need to wear them full time. QP will ensure that all adaptive equipment are properly documented in each resident's PCP going forward. QP updated Client #6's PCP to address his drooling with specific guidelines as to how staff should support him in addressing his drooling. QP will inservice staff on the specific guidelines outlines in the PCP. Plan to prevent re-occurrence: Monitoring will occur through random observations and chart audits by the QIP, LPN and PD	11/12/21

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W 240	Continued From page 5 A. During observations in the home throughout the survey on 9/13 - 9/14/21, client #6 wore eyeglasses. The eyeglasses consistently slipped down his face to the tip of his nose. Various staff prompted the client to push his eyeglasses up on his face or pushed them up for him. Review on 9/14/21 of client #6's vision examination report dated 2/16/21 revealed the client has myopia and "wear glasses full time." Additional review of the client's IPP dated 2/17/21 revealed under Adaptive equipment, "NA". Further review of the IPP indicated no information regarding the client's eyeglasses or their use. Interview on 9/14/21 with the Program Director (PD) confirmed client #6 wears eyeglasses; however, his IPP does not include any information regarding his eyeglasses. B. During observations in the home throughout the survey on 9/13 - 9/14/21, client #6 drooled consistently. Various staff prompted the client to obtain a napkin and wipe the drool from his mouth. Review on 9/14/21 of client #6's IPP dated 2/17/21 revealed no information regarding client #6's drooling or specific guidelines as to how staff should support the client with addressing his drooling. Interview on 9/14/21 with the PD confirmed client #6's IPP did not include any information to address his drooling.	W 240		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1)	W 252		

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W 252	Continued From page 6 Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure all data relative to the accomplishment of specified objectives was documented in measurable terms. This affected 1 of 4 audit clients (#3). The finding is: During evening observations in the home on 9/13/21 at 5:10pm, client #3 ran out of a side door of the home and down a side street. Two staff immediately ran after him and brought him back to the home. Review on 9/14/21 of client #3's Behavior Support Plan (BSP) dated 5/22/20 revealed an objective, "Across all settings, I will decrease disruptive behaviors as evidenced by targeted behavior(s) occurring with daily average of .04 or less hourly interval per month 6 out of 12 consecutive months." The BSP identified target behaviors of refusing to participate in scheduled and essential activities of daily living, aggression, self-injury, agitation episode, leaving supervised area, elopement and inappropriate toileting. Elopement was defined as, "Anytime [Client #3] leaves supervised area and exits the building to run outside of home or scheduled place..." The plan also noted, "Document appropriately." Review on 9/14/21 of client #3's objective training book revealed no documentation of the	W 252	W252 GHM will inservice staff on the importance of following residents' BSP's and documenting appropriately. Plan to prevent re-occurrence: Monitoring will be conducted by the GHM, QP and PD monthly for the next six months to ensure compliance.	11/12/21

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W 252	Continued From page 7 elopement behavior from 9/13/21 at 5:10pm. Interview on 9/14/21 with the Program Director confirmed client #3's elopement behavior should have been documented as indicated.	W 252		
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 observation, record review and interview, the facility failed to ensure written informed consent was obtained from the guardian for the use of a restrictive chest harness for client #2. This affected 1 of 4 audit clients. The finding is: During observations in the home on 9/14/21 at 7:00 AM, Staff G applied a restrictive chest harness on client #2, prior to him getting on the school bus. Review on 9/14/21 of client's #2's Behavior Support Plan (BSP) addendum dated 5/24/21 did not identify any written informed consent from the guardian for the restricted chest harness. Interview on 9/14/21 with the Program Director revealed that facility had not obtained consent for the restrictive chest harness.	W 263	W263 QP will work closely with the psychologist and to obtain an addendum to Client #2's BSP to incluse the use of restrictive chest harness on the school bus as required by the school and will reach out to guardian to obtain consent for the use of restrictive chest harness on the school bus. Plan to prevent reoccurrence: Monitoring will be conducted by IDD and QA during random chart audits.	11/12/21
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3)	W 288		

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W 288	Continued From page 8 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 observation, record review and interview, the facility failed to ensure a technique to manage client #2's inappropriate behavior was included in a formal active treatment program. This affected 1 of 4 audit clients. The finding is: During observations in the home on 9/14/21 at 7:00 AM, Staff G applied a restrictive chest harness on client #2, prior to him getting on the school bus. Review on 9/14/21 of client #2's Behavior Support Plan (BSP) and Individual Program Plan (IPP) did not include any information about the use of a restrictive chest harness for transportation. Interview on 9/14/21 with the Program Director (PD) revealed that when client #2 started school on 8/23/21, the school district recommended that he wear a restrictive vest since he did not remain in his seat during transport. The PD indicated that client #2 had a psychology review meeting planned for next week but at the present time, he did not have any measures in his BSP or IPP to wear the restrictive chest harness.	W 288	QP will work closely with the psychologist to obtain an addndum to Client #2 s BSP to includethe use of restrictive chest harness for transportation to and from school. Plan to prevent reoccurrence: Monitoring will be conducted by PD and QA during random chart audits.	11/12/2021