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	34G114	A. BUILDING _____ B. WING _____	03/07/2023

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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 025	Arrangement with Other Facilities CFR(s): 483.475(b)(7) §403.748(b)(7), §418.113(b)(5), §441.184(b)(7), §460.84(b)(8), §482.15(b)(7), §483.73(b)(7), §483.475(b)(7), §485.625(b)(7), §485.920(b)(6), §494.62(b)(6). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and	E 025		

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

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E 025	Continued From page 1 procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This STANDARD is not met as evidenced by: Based on interview and review of the facility's Emergency Preparedness Manual (EP), the facility failed to document pre-arranged accommodations for clients in the event services could not be delivered in the home. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) in the home. The findings is: Review on 3/6/23 of the facility's 2022 EP Plan revealed there was no listing of accommodations or agreements for housing for emergency purposes. During an interview on 3/7/23, the Area Supervisor (AS) acknowledged that the EP did not list any specific location as an option to relocate clients	E 025		
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), §485.542(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	E 030		

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E 030	Continued From page 2	E 030		

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:
(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:

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E 030	Continued From page 3 (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: (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	E 030		

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E 030	Continued From page 4 Federal, State and local laws. This potentially affected clients #1, #2, #3, #4, #5, #5, and #6. The finding is: Review on 3/6/23 of the facility's EP Plan did not include any information on the clients who reside in the home. Further review revealed the EP Plan did not include any information about the direct care staff who worked in the home. During an interview on 3/7/23, the Area Supervisor (AS) confirmed the EP plan should have included both the information about the clients and the direct care staff.	E 030		
E 037	EP Training Program CFR(s): 483.475(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		

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E 037	Continued From page 5 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 6	E 037		

arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.
(v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures.

*[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under

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arrangement, and volunteers, consistent with their expected role.
(ii) Provide emergency preparedness training at least annually.
(iii) Maintain documentation of all emergency preparedness training.
(iv) Demonstrate staff knowledge of emergency procedures.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment.
(v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures.

*[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:
(i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,

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personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least every 2 years.
(iii) Maintain documentation of the training.
(iv) Demonstrate staff knowledge of emergency procedures.
(v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures.

*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.
This STANDARD is not met as evidenced by:
Based on document review and interviews, the facility failed to ensure direct care staff were adequately trained on the facility's emergency preparedness (EP) pan. The finding is:

Review on 3/6/23 of the facility's EP manual dated 2/23/22 did not include any information regarding training of staff.

During an interview on 3/7/23, the Area Supervisor (AS) confirmed there was no

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E 037	Continued From page 9 information included in the EP concerning training of the staff.	E 037		
E 039	EP Testing Requirements CFR(s): 483.475(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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community-based or individual, facility-based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:
(i) Participate in a full-scale exercise that is community based every 2 years; or
(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional

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exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:
(i) Participate in an annual full-scale exercise that is community-based; or
(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or
(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.
(ii) Conduct an additional annual exercise that may include, but is not limited to the following:
(A) A second full-scale exercise that is community-based or a facility based functional exercise; or
(B) A mock disaster drill; or
(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop

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E 039	Continued From page 12 exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop	E 039		

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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 039	Continued From page 13 exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the	E 039		

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E 039	Continued From page 14 PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]:	E 039		

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E 039	Continued From page 15 (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 16 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is	E 039		

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E 039	Continued From page 17 led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This STANDARD is not met as evidenced by: Based on document review and interviews, the facility failed to ensure a full scale evacuation, mock drill or an annual tabletop activity was conducted and included in the facility's Emergency Preparedness Plan (EP). The finding is: Review on 3/6/23 of the facility's EP Plan	E 039		

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E 039	Continued From page 18 revealed there was no annual tabletop conducted. Further review indicated there was no documentation about a tabletop conducted for 2021 or 2022. During an interview on 3/7/23, the Area Supervisor (AS) confirmed the facility EP did not have documentation detailing a annual tabletop activity.	E 039		
W 125	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(3) The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on record review, observation and interviews, the facility failed to ensure clients had the right to a legal guardian. This affected 1 of 3 audit clients (#4). The finding is: Review of 3/6/23 of client #4's record revealed he had been admitted to the home on 11/16/22. The client's Individual Program Plan (IPP) dated 12/14/22 indicated the client acted as his own guardian. Additional review of the record indicated the client was 19 years old and had a diagnosis of Mild Intellectual Disability, Autism, ADHD combined by history of unexplained anxiety and depression disorder. During an interview on 3/6/23, when asked if he liked living in the home he stated, "So-So". Client #4 went on the say he was moving back home to Ohio in May. When client #4 was asked why he	W 125		

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W 125	Continued From page 19 takes the medication Invega, he reported he did not know why. When asked again he said, "Ask my Mom." During an interview on 3/7/23, Staff B reported that client #4 should not be living in the home, due to the fact that he is on a "different level' of the other clients living in the home. Additional interview revealed client #4 has told Staff B that he wants to move back to Ohio. During an interview on 3/6/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #4 was currently acting as his own guardian and this was his status when he was admitted to the home. QIDP revealed that he had a conversation with client #4's mother when client #4 was admitted to the facility about taking guardianship but she did not seem interested.	W 125		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to obtain needed initial assessments for 1 newly admitted client (#4) no later than 30 days after admission. The findings are: A. Review on 3/6/23 of client #4's Individual Program Plan (IPP) dated 12/14/22 revealed he was admitted to the facility on 11/16/22. Further of client #4's record revealed he does not have a Social Work evaluation.	W 210		

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W 210	Continued From page 20 B. Review on 3/6/23 of client #4's IPP dated 12/14/22 revealed he was admitted to the facility on 11/16/22. Further of client #4's record revealed he does not have an initial visual examination. During an interview on 3/6/23, the Area Supervisor (AS) confirmed that client #4 does not have a Social Work evaluation or an initial visual examination.	W 210		
W 216	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include physical development and health. This STANDARD is not met as evidenced by: Based on record review and interviews the facility failed to ensure 1 newly admitted clients' (#4) annual physcial was done within 30 days of admission. The finding is: Review on 3/6/23 of client #4's current record revealed there was no current annual physical examination. Further review revealed there was no information on when client #4 had his last physical. During an interview on 3/7/23, the facility's nurse confirmed client #4 did not have a physical examination.	W 216		
W 217	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility	W 217		

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W 217	Continued From page 21 failed to ensure 1 of 3 audit clients (#1) nutritional assessments have been updated. The finding is: Review on 3/6/23 of client #1's record revealed there was no Nutritional assessment for 2022 or 2021. During an interview on 3/7/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's record did not include a Nutritional assessment.	W 217		
W 218	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include sensorimotor development. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the facility failed to obtain a needed sensorimotor assessment for 1 newly admitted client (#4) within 30 days of admission. The finding is: Review on 3/6/23 of client #4's Individual Program Plan (IPP) dated 12/14/22 revealed he was admitted to the facility on 11/16/22. Further review revealed client #4 did not have a Occupational Therapy (OT) assessment. During an interview on 3/6/23, the Area Supervisor (AS) confirmed that client #4 does not have a OT assessment.	W 218		
W 220	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include speech and language development. This STANDARD is not met as evidenced by: Based on record reviews and interviews, the	W 220		

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W 220	Continued From page 22 facility failed to ensure 1 newly admitted client (#4) received his initial speech/language assessments within 30 days of admission. The finding is: Review on 3/6/23 of client #4's Individual Program Plan (IPP) dated 12/14/22 revealed he was admitted to the facility on 11/16/22. Further review revealed client #4 did not have a speech/language assessment. During an interview on 3/7/23, the facility's nurse confirmed client #4 did not have a speech/language assessment.	W 220		
W 221	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3)(v) The comprehensive functional assessment must include auditory functioning. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure an physical examination for 1 newly admitted client (#4) was done within 30 days of admission. The finding is: Review on 3/6/23 of client #4's Individual Program Plan (IPP) dated 12/14/22 stated the client was admitted to the facility on 11/16/22. Further review revealed there was no documentation indicating client #4 had received a physical. During an interview on 3/7/23, the facility's nurse confirmed client #4's physical examination was not done within 30 days of his admission to the facility. During an interview on 3/7/23, the Area	W 221		

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W 221	Continued From page 23 Supervisor (AS) revealed the facility had COVID-19 in late 2022; but there was no documentation explaining why client #4's physical examination was not conducted on time.	W 221		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 audit clients (#1) received a continuous active treatment program consisting of needed interventions and services as identified in the Individual Program Plan (IPP) in the area of adaptive dining equipment. The finding is: During mealtime observations in the home on 3/6 - 7/23, client #1 was observed drinking from regular glasses. Further observations revealed client #1 was eating from a scoop plate and using a regular spoon with a red foam handle on the end. Review on 3/6/3 of client #1's IPP dated 8/12/22 revealed his adaptive equipment when eating is a divided plate, grip angled spoon and fork, and desk mug.	W 249		

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W 249	Continued From page 24 During an interview on 3/6/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1 should be using his divided plate, grip angled spoon and fork, and desk mug during meals.	W 249		
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 only conducted with the written informed consent of a legal guardian. This affected 3 of 3 audit clients (#1, #4 and #5). The findings are: During observations in the home on 3/6/23, the surveyor noticed that there was a lock on the pantry door. Further observations revealed staff had to use a key to unlock the pantry. A. Review on 3/6/23 of client #1's Individual Program Plan (IPP) dated 8/12/22 did not include a signed consent allowing the pantry to be locked in the home. B. Review on 3/6/23 of client #4's IPP dated 12/14/22 did not include a signed consent allowing the pantry to be locked in the home. C. Review on 3/6/23 of client #5's IPP dated 4/8/22 did not include a signed consent allowing the pantry to be locked in the home.	W 263		

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W 263	Continued From page 25 During an interview on 3/6/23, Staff A confirmed the pantry is always locked to prevent clients in the home from taking food. During an interview on 3/6/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed the pantry should not be locked, due to the fact clients #1, #4 and #5 do not have signed consents allowing for it to be locked.	W 263		
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 interview, nursing services failed to ensure that staff were sufficiently trained in the wearing of face masks and of taking of temperatures of visitors. This potentially effected all clients (#1, #2, #3, #4 and #5) residing in the facility. The findings are: A. During observations in the home on 3/6/23 when the surveyor entered the home at 9:33am, the surveyors' temperature was not taken. At no time was the surveyor asked to take their temperature. The surveyor reentered the home on 3:31pm, and their temperature was not taken until 4:18pm when the surveyor asked the Qualified Intellectual Disabilities Professional (QIDP) questions about the protocol for taking the temperatures of visitors.	W 340		

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During an interview on 3/6/23, the QIDP revealed the surveyors' temperature should have been taken when they first entered the home.

B. During observations in the home on 3/6/23 when the surveyor entered the home at 9:33am, the three staff working in the home were not wearing face masks. The three staff did not put on face masks until the surveyor began asking questions.

During observations in the home on 3/7/23 at 6:47am, Staff D had their face mask below her nose and mouth. Further observations revealed there were three clients up and dressed and in the proximity of Staff D.

During observations in the home on 3/7/23 at 8:09am, Staff D was seen talking to a client, while standing less than arms length from them. Further observations revealed Staff D's face mask was not covering their nose or mouth.

Review on 3/6/23 of a notice on the bulletin board revealed, "Please wear a mask when inside".

During an interview on 3/6/23, Staff C stated staff are to wear face masks at all times while they are working in the home.

During an interview on 3/7/23 at 8:12am, Staff D pulled up their face masks when the surveyor began asking questions about the how staff are to wear their face masks.

During an interview on 3/7/23, the Area Supervisor stated staff are to wear face masks at all times while they are working in the home.

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 _____	03/07/2023

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 351	Continued From page 27	W 351		
W 351	COMPREHENSIVE DENTAL DIAGNOSTIC SERVICE CFR(s): 483.460(f)(1) Comprehensive dental diagnostic services include a complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's condition not later than one month after admission to the facility (unless the examination was completed within twelve months before admission). This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure a dental examination for 1 newly admitted client (#4) was done within 30 days of admission. The finding is: Review on 3/6/23 of client #4's Individual Program Plan (IPP) dated 12/14/22 stated the client was admitted to the facility on 11/16/22. Further review revealed client #4's dental examination was conducted on 2/3/23. During an interview on 3/7/23, the facility's nurse confirmed client #4's dental examination was not done within 30 days of his admission to the facility. During an interview on 3/7/23, the Area Supervisor (AS) revealed the facility had COVID-19 in late 2022; but there was no documentation explaining why client #4's dental examination was not conducted on time.	W 351		
W 441	EVACUATION DRILLS CFR(s): 483.470(i)(1)	W 441		

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W 441	Continued From page 28 and under varied conditions to- This STANDARD is not met as evidenced by: Based on the review of the fire drill reports and interviews, the facility failed to ensure fire evacuation drills were conducted at varied times. This potentially affected all the clients (#1, #2, #3, #4, #5 and #6) residing in the home. The finding is: Review on 3/6/23 of the facility's fire drills revealed revealed there were no fire drills held in 2022. During an interview on 3/6/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed there were no fire drills conducted in 2022.	W 441		
W 455	INFECTION CONTROL CFR(s): 483.470(l)(1) There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a sanitary environment was provided to avoid transmission of possible infection and prevent possible cross-contamination. This potentially affected 2 of 6 (#4 and #5) clients in the home. The finding is: During breakfast observations in the home on 3/7/23 at 7:49am, client #4 used the same spoon to scoop peanut butter that he had used to eat his cereal with.	W 455		

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W 455	Continued From page 29 During breakfast observations in the home on 3/7/23 at 8:06am, a staff person assisted another client to scoop peanut butter from the same jar client #4 had put his spoon in. Further observations revealed the client then ate his toast with peanut butter. During an interview on 3/7/23, Staff D stated the peanut butter should have been thrown away after client #4 put his spoon in it. During an interview on 3/7/23, client #4 stated the spoon he used to scoop the peanut butter was the same one that he used to eat his cereal with. During an interview on 3/7/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed the peanut butter should have been thrown away after client #4 put his spoon in it.	W 455		
W 460	FOOD AND NUTRITION SERVICES CFR(s): 483.480(a)(1) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure each client received a nourishing, well balanced diet including modified specially prescribed diet as prescribed. This affected 1 of 3 audit clients (#1). The finding is: During breakfast observations in the home on 3/7/23 at 7:41am, client #1 took a bite out of a whole slice of toast. At 7:42am, client #1 stuffed	W 460		

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W 460	Continued From page 30 the remainder of the toast into his mouth. Further observations revealed at 7:47am, client #1 stuffed a second slice of toast into his mouth. At no time was client #1's slices of toast cut into bite size pieces. During an interview on 3/7/23, Staff D stated she was the only one working in the kitchen and could not bring a second knife to the table. Additional interview revealed she was aware that client #1's food is suppose to be cut into bite size pieces. Review on 3/6/23 of client #1's Individual Program Plan (IPP) dated 8/12/22 indicted his food is to be cut into bite size pieces. During an interview on 3/7/23, the Qualified Intellectual Disabilities Professional (QIDP) confirmed client #1's food is to be cut into bite size pieces.	W 460		
W 477	MENUS CFR(s): 483.480(c)(1)(i) Menus must be prepared in advance. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a copy of menus was available for meal planning. The finding is: During 2 of 2 meal preparation observations in the home on 3/6 - 7/23, no updated menus were available for review. During interviews on 3/6 - 7/23, with Staff A and Staff B revealed they used to have menus in the home to follow; however, there are no updated	W 477		

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W 477	Continued From page 31 menus. Additional interview indicated no menus had been available for several months. When asked how they know what to cook, the staff indicated they use food available in the home. Further interview with Staff A and Staff B revealed either the Nutritionist or the Site Supervisor would drop off the updated menus. During an interview on 3/7/23, the Area Supervisor (AS) confirmed the menus for the home have not been updated. Additional interview revealed it is the responsibility of the Nutritionist to update the menu book.	W 477		