CENTERS FOR MEDICARE & MEDICAID SER	VICES		OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL AND PLAN OF CORRECTION IDENTIFICATION N		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
34G114	B. WIN	3	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 DEFICIENC (EACH DEFICIENCY MUST BE PRECEDED E REGULATORY OR LSC IDENTIFYING INFORM	Y FULL PREI		ON SHOULD BECOMPLETIONIE APPROPRIATEDATE
E 025 Arrangement with Other Facilities CFR(s): 483.475(b)(7)	E	025	
§403.748(b)(7), §418.113(b)(5), §441. §460.84(b)(8), §482.15(b)(7), §483.73 §483.475(b)(7), §485.625(b)(7), §485. §494.62(b)(6).	(b)(7),		
[(b) Policies and procedures. The [fac develop and implement emergency pro- policies and procedures, based on the plan set forth in paragraph (a) of this s assessment at paragraph (a)(1) of this and the communication plan at paragr this section. The policies and procedu- be reviewed and updated at least ever [annually for LTC facilities]. At a minim policies and procedures must address following:]	eparedness emergency ection, risk section, aph (c) of ires must y 2 years um, the		
*[For Hospices at §418.113(b), PRFTs §441.184,(b) Hospitals at §482.15(b), Facilities at §483.73(b):] Policies and p (7) [or (5)] The development of arrang other [facilities] [and] other providers to patients in the event of limitations or co operations to maintain the continuity o to facility patients.	and LTC procedures. ements with p receive essation of		
*[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CI §485.920(b) and ESRD Facilities at §4 Policies and procedures. (7) [or (6), (8 development of arrangements with oth [facilities] [or] other providers to receiv in the event of limitations or cessation operations to maintain the continuity o to facility patients.	94.62(b):] )] The er e patients of		
*[For RNHCIs at §403.748(b):] Policies		TITLE	(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SUR COMPLETE         NAME OF PROVIDER OR SUPPLIER       34G114       B. WING       03/07/20			AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
00/01/20	STATEMENT	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	` '		E CONSTRUCTION	(X3) DAT	E SURVEY
			34G114	B. WING			03/	07/2023
	NAME OF P	F PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
FOREST CREEK GROUP HOME       5117 FOREST CREEK DRIVE         RALEIGH, NC 27606	FOREST	ST CREEK GROUP HOM	ΛE					
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	PRÉFIX	X (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF	) BE	(X5) COMPLETION DATE
E 025       Continued From page 1       E 025         arrangements with other RNHCls and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCl patients.       E 025         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.       E 030         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 030         CFR(s): 483.475(c)(1)       §443.475(c)(1), §446.54(c)(1), §448.113(c)(1), §443.742(c)(1), §448.542(c)(1), §486.360(c)(1), §485.727(c)(1), §483.475(c)(1), §485.625(c)(1), §485.527(c)(1), §486.525(c)(1), §485.527(c)(1), §486.525(c)(2), §485.527(c)(1), §486.525(c)(2), §485.527(c)(2), §486.525(c)(2), §485.527(c)(2), §486.525(c)(2), §485.527(c)(2), §486.525(c)(2), §485.527(c)(2), §486.52		procedures. (7) The arrangements with providers to receive limitations or cessa the continuity of non- patients. This STANDARD in Based on interview Emergency Prepare facility failed to doc accommodations for could not be delived potentially affected and #6) in the home Review on 3/6/23 of revealed there was or agreements for th purposes. During an interview Supervisor (AS) ac not list any specific relocate clients Names and Contac CFR(s): 483.475(c) §403.748(c)(1), §483 §485.68(c)(1), §483 §485.727(c)(1), §483 §485.727(c)(1), §483 §491.12(c)(1), §494 [(c) The [facility mu emergency prepare that complies with f	e development of other RNHCIs and other e patients in the event of tion of operations to maintain n-medical services to RNHCI s not met as evidenced by: v and review of the facility's edness Manual (EP), the ument pre-arranged or clients in the event services red in the home. This all clients (#1, #2, #3, #4, #5 e. The findings is: f the facility's 2022 EP Plan no listing of accommodations nousing for emergency on 3/7/23, the Area knowledged that the EP did location as an option to et Information 0(1) 16.54(c)(1), §418.113(c)(1), 5.542(c)(1), §485.625(c)(1), 3.475(c)(1), §485.625(c)(1), 3.5920(c)(1), §486.360(c)(1), 4.62(c)(1). st develop and maintain an edness communication plan Federal, State and local laws					

Facility ID: 921876

If continuation sheet Page 2 of 32

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G114	B. WING			03/0	07/2023
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	IE			117 FOREST CREEK DRIVE ALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	¢	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 030	communication plan following: (1) Names and com following: (i) Staff. (ii) Entities providing (iii) Patients' physici (iv) Other [facilities] (v) Volunteers. *[For Hospitals at §- §485.625(c)] The co- include all of the fol (1) Names and com following: (i) Staff. (ii) Entities providing (iii) Patients' physici (iv) Other [hospitals (v) Volunteers. *[For RNHCIs at §4 communication plan following: (1) Names and com following: (1) Names and com following: (1) Names and com following: (i) Staff. (ii) Entities providing (iii) Next of kin, gua (iv) Other RNHCIs. (v) Volunteers. *[For ASCs at §416 plan must include a	r LTC facilities]. The n must include all of the tact information for the g services under arrangement. ans 482.15(c) and CAHs at ommunication plan must lowing: tact information for the g services under arrangement. ans and CAHs]. 03.748(c):] The n must include all of the tact information for the g services under arrangement. rdian, or custodian.	EO	30			

Facility ID: 921876

If continuation sheet Page 3 of 32

		AND HUMAN SERVICES					FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	01	(X3) DATE SURVEY COMPLETED	
		34G114	B. WING				03/	07/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, Z	IP CODE		
FOREST	CREEK GROUP HOM	ΛE			117 FOREST CREEK DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD	BE	(X5) COMPLETION DATE
E 030	<ul> <li>(iii) Patients' physici</li> <li>(iv) Volunteers.</li> <li>*[For Hospices at § communication plant following: <ul> <li>(1) Names and confollowing:</li> <li>(i) Hospice employed</li> <li>(ii) Entities providing</li> <li>(iii) Patients' physici</li> <li>(iv) Other hospices.</li> </ul> </li> <li>*[For HHAs at §484 plan must include at (1) Names and confollowing: <ul> <li>(i) Staff.</li> <li>(ii) Entities providing</li> <li>(iii) Patients' physici</li> <li>(iv) Volunteers.</li> </ul> </li> <li>*[For OPOs at §486 plan must include at (2) Names and confollowing: <ul> <li>(i) Staff.</li> <li>(ii) Entities providing</li> <li>(iii) Entities providing</li> <li>(iii) Patients' physici</li> <li>(iv) Volunteers.</li> <li>*[For OPOs at §486 plan must include at (2) Names and confollowing:</li> <li>(i) Staff.</li> <li>(ii) Entities providing</li> <li>(ii) Entities providing</li> <li>(iii) Volunteers.</li> <li>(iv) Volunteers.</li> <li>(iv) Other OPOs.</li> </ul> </li> </ul>	g services under arrangement. ians. 418.113(c):] The n must include all of the tact information for the ees. g services under arrangement. ians. 4.102(c):] The communication all of the following: tact information for the g services under arrangement. ians. 6.360(c):] The communication all of the following: tact information for the g services under arrangement. ians. 6.360(c):] The communication all of the following: tact information for the g services under arrangement. donor hospitals in the OPO's	EO	030	DEFICIENC	Y)		
	This STANDARD is Based on documer facility failed to ensu Preparedness (EP)	s not met as evidenced by: nt review and interview, the						

Facility ID: 921876

If continuation sheet Page 4 of 32

		AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G114	B. WING			03/	07/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	NE			117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 030	affected clients #1, The finding is: Review on 3/6/23 or include any informa in the home. Furthed did not include any care staff who work During an interview Supervisor (AS) con have included both clients and the direct EP Training Program CFR(s): 483.475(d) §403.748(d)(1), §44 §441.184(d)(1), §44 §443.73(d)(1), §48 §485.68(d)(1), §48 §485.68(d)(1), §48 §485.727(d)(1), §48 §491.12(d)(1). *[For RNCHIs at §4 Hospitals at §482.1 at §484.102, REHs under §485.727, OF RHC/FQHCs at §48 (1) Training program the following: (i) Initial training in et	local laws. This potentially #2, #3, #4, #5, #5, and #6. f the facility's EP Plan did not ation on the clients who reside er review revealed the EP Plan information about the direct ted in the home. f on 3/7/23, the Area nfirmed the EP plan should the information about the ct care staff. m 0(1) 16.54(d)(1), §418.113(d)(1), 50.84(d)(1), §482.15(d)(1), 3.475(d)(1), §482.15(d)(1), 3.475(d)(1), §485.625(d)(1), 3.475(d)(1), §486.360(d)(1), 3.5.920(d)(1), §486.360(d)(1), 403.748, ASCs at §416.54, 5, ICF/IIDs at §483.475, HHAs at §485.542, "Organizations" POs at §486.360, 91.12:] m. The [facility] must do all of emergency preparedness	EC	030			
	staff, individuals pro arrangement, and v expected roles.	lures to all new and existing oviding services under volunteers, consistent with their ncy preparedness training at					

Facility ID: 921876

If continuation sheet Page 5 of 32

OF DEFICIENCIES F CORRECTION ROVIDER OR SUPPLIER	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 34G114	A. BUILDI	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
ROVIDER OR SUPPLIER	34G114				
ROVIDER OR SUPPLIER		B. WING			03/07/2023
			STREET ADDRESS, CITY, S		
CREEK GROUP HOM	ΛE		5117 FOREST CREEK DR RALEIGH, NC 27606	RIVE	
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	X (EACH CORRECT CROSS-REFERENC	IVE ACTION SHOULD BE ED TO THE APPROPRIATE	(X5) COMPLETIO DATE
<ul> <li>(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</li> <li>Continued From page 5</li> <li>(iii) Maintain documentation of all emergency preparedness training.</li> <li>(iv) Demonstrate staff knowledge of emergency procedures.</li> <li>(v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures.</li> <li>*[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following:</li> <li>(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.</li> <li>(ii) Demonstrate staff knowledge of emergency procedures.</li> <li>(iii) Provide emergency preparedness training at least every 2 years.</li> <li>(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.</li> <li>(v) Maintain documentation of all emergency preparedness training.</li> <li>(vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.</li> </ul>			037		
	(EACH DEFICIENCY REGULATORY OR L Continued From pa (iii) Maintain docum preparedness traini (iv) Demonstrate st procedures. (v) If the emergenc procedures are sign must conduct traini procedures are sign must conduct traini procedures. *[For Hospices at § hospice must do all (i) Initial training in a policies and proced hospice employees services under arra expected roles. (ii) Demonstrate sta procedures. (iii) Demonstrate sta procedures. (iii) Provide emerge least every 2 years (iv) Periodically rev emergency prepare employees (includin special emphasis p procedures necess others. (v) Maintain docum preparedness traini (vi) If the emergency must conduct traini	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	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFITAG         Continued From page 5       (iii) Maintain documentation of all emergency preparedness training.       E (iii) Maintain documentation of all emergency procedures.         (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.       (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	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECT CROSS-REFERENCE CROSS-REFERENCE DEI         Continued From page 5       E 037         (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 Hospice 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) Preiodically 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	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFIX TAG       (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         Continued From page 5       (iii) Maintain documentation of all emergency preparedness training.       E 037         (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.       E 037         *[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) Demonstrate staff knowledge of emergency procedures.       (iii) Demonstrate staff knowledge of emergency procedures.         (iii) Demonstrate staff knowledge of emergency procedures.       (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.         (v) Maintain documentation of all emergency preparedness training.       (v) Maintain documentation of all emergency preparedness training on the updated policies and procedures are significantly updated, the hospice must conduct training on the updated policies and

If continuation sheet Page 6 of 32

			(V2) MILLI			). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		34G114	B. WING		03	/07/2023
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
OREST	CREEK GROUP HOM	ΛE		5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
E 037	expected roles. (ii) After initial trainipreparedness trainif (iii) Demonstrate staprocedures. (iv) Maintain documpreparedness trainif (v) If the emergence procedures are signed must conduct trainiprocedures. *[For PACE at §460 organization must of (i) Initial training in epolicies and proceded staff, individuals pro- arrangement, contrevolunteers, consisted (ii) Provide emergence least every 2 years. (iii) Demonstrate staprocedures, including what to do, where the case of an emergence (iv) Maintain docum (v) If the emergence procedures are signed must conduct training procedures. *[For LTC Facilities Program. The LTC following: (i) Initial training in epoletics (ii) Initial training in epoletics (ii) Initial training in epoletics (iii) Initial training in epoletics (iv) Initial training in epo	volunteers, consistent with their ng, provide emergency ing every 2 years. aff knowledge of emergency nentation of all emergency ing. y preparedness policies and nificantly updated, the PRTF ng on the updated policies and 0.84(d):] (1) The PACE do all of the following: emergency preparedness lures to all new and existing oviding on-site services under actors, participants, and ent with their expected roles. ncy preparedness training at aff knowledge of emergency ng informing participants of o go, and whom to contact in ncy. nentation of all training. by preparedness policies and nificantly updated, the PACE ng on the updated policies and at §483.73(d):] (1) Training facility must do all of the emergency preparedness lures to all new and existing	EO	37		

If continuation sheet Page 7 of 32

		AND HUMAN SERVICES				FORM	D: 03/08/202 MAPPROVE D. 0938-039		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION		TE SURVEY MPLETED		
		34G114	B. WING			03	8/07/2023		
NAME OF F	PROVIDER OR SUPPLIER		[	S	STREET ADDRESS, CITY, STATE, ZIP CO				
FOREST	CREEK GROUP HOM	ЛЕ	5117 FOREST CREEK DRIVE RALEIGH, NC 27606						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE		
E 037	Continued From pa	age 7	E 0	37					
	arrangement, and very expected role.	volunteers, consistent with their							
	<ul><li>(ii) Provide emerge least annually.</li><li>(iii) Maintain docum preparedness train</li></ul>	ncy preparedness training at nentation of all emergency ing. taff knowledge of emergency							
CORF (i) Pro prepar and ex under with th (ii) Pro least e (iii) Ma (iv) De procee and as the CO their fi includ alarm equipr (v) If procee must o	CORF must do all of (i) Provide initial tra- preparedness polic and existing staff, in under arrangement with their expected (ii) Provide emerge least every 2 years (iii) Maintain docum (iv) Demonstrate st procedures. All new and assigned spect the CORF's emerge their first workday. include instruction in alarm systems and equipment. (v) If the emergen procedures are sign	ining in emergency ies and procedures to all new ndividuals providing services t, and volunteers, consistent roles. ncy preparedness training at							
	The CAH must do a (i) Initial training in policies and proceed reporting and exting	5.625(d):] (1) Training program. all of the following: emergency preparedness dures, including prompt guishing of fires, protection, ary, evacuation of patients,							

If continuation sheet Page 8 of 32

		AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		34G114	B. WING	i		03/	07/2023
NAME OF F	PROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
FOREST	CREEK GROUP HOM	ΛE			5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
E 037	cooperation with fire authorities, to all ne individuals providing and volunteers, cor roles. (ii) Provide emerge least every 2 years. (iii) Maintain docum (iv) Demonstrate st procedures. (v) If the emergen procedures are sign must conduct traini procedures. *[For CMHCs at §4 CMHC must provid preparedness polic and existing staff, in under arrangement with their expected documentation of th demonstrate staff k procedures. There emergency prepare years. This STANDARD is Based on document facility failed to ensi adequately trained preparedness (EP) Review on 3/6/23 o dated 2/23/22 did n regarding training of During an interview	ests, fire prevention, and efighting and disaster aw and existing staff, g services under arrangement, hisistent with their expected ncy preparedness training at  tentation of the training. taff knowledge of emergency rcy preparedness policies and nificantly updated, the CAH ng on the updated policies and 85.920(d):] (1) Training. The le initial training in emergency ties and procedures to all new individuals providing services t, and volunteers, consistent roles, and maintain the training. The CMHC must knowledge of emergency eafter, the CMHC must provide edness training at least every 2 s not met as evidenced by: nt review and interviews, the ure direct care staff were on the facility's EP manual not include any information of staff.	E	037			
		nfirmed there was no					

If continuation sheet Page 9 of 32

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA <sup>-</sup>	TE SURVEY		
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED		
		34G114	B. WING		03	/07/2023		
AME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP COD	Ξ			
OREST	CREEK GROUP HOM	ΛE		5117 FOREST CREEK DRIVE RALEIGH, NC 27606				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE		
E 037	information include	age 9 d in the EP concerning training	E 037					
E 039	of the staff. E 039 EP Testing Requirements CFR(s): 483.475(d)(2)		E 039					
	§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, REH at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs a §491.12, and ESRD Facilities at §494.62]:							
		cility] must conduct exercises ncy plan annually. The [facility] pllowing:						
	community-based e (A) When a comm accessible, conduc exercise every 2 ye (B) If the [facilit natural or man-mac	unity-based exercise is not t a facility-based functional						
	exempt from engage community-based of functional exercise actual event. (ii) Conduct an add years, opposite the	itional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of						

Facility ID: 921876

If continuation sheet Page 10 of 32

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
		IDENTIFICATION NONDER.	A. BUILDIN	IG		
		34G114	B. WING		03/	07/2023
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5117 FOREST CREEK DRIVE		
FOREST	CREEK GROUP HOM	ΛE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
E 039	community-based of functional exercises; (B) A mock disaster (C) A tabletop exercises; (B) A mock disaster (C) A tabletop exercises; a facilitator and inclu- a narrated, clinically scenario, and a set directed messages; designed to challen (iii) Analyze the [fac maintain document exercises, and emerge [facility's] emergend *[For Hospices at 4 (2) Testing for hosp patient's home. The exercises to test the annually. The hosp patient's home. The exercises to test the annually. The hosp (i) Participate in a fac community based of (A) When a commu- accessible, conduct functional exercise (B) If the hospice effective man-made emergence the emergency plane engaging in its next community-based functionset of the emergency (ii) Conduct an addo opposite the year the exercise under para- is conducted, that re- to the following: (A) A second full-s	or individual, facility-based ; or r drill; or cise or workshop that is led by ludes a group discussion using y-relevant emergency of problem statements, , or prepared questions age an emergency plan. cility's] response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed.	E 03	39		

		AND HUMAN SERVICES			FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G114	B. WING		03/0	07/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 5117 FOREST CREEK DRIVE		
FOREST	CREEK GROUP HOM	1E		RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	exercise; or (B) A mock disaster (C) A tabletop exer a facilitator and incl a narrated, clinically scenario, and a set directed messages, designed to challen (3) Testing for hosp care directly. The r exercises to test the year. The hospice (i) Participate in an is community-based (A) When a commu- accessible, conduct facility-based function (B) If the hospice ex- man-made emergent the emergency plane engaging in its next based or facility-based following the onset (ii) Conduct an addr may include, but is (A) A second full-sec community-based or exercise; or (B) A mock disaster (C) A tabletop exer facilitator that include narrated, clinically-r and a set of probler messages, or prepa- challenge an emerge (iii) Analyze the hospice	er drill; or rcise or workshop that is led by udes a group discussion using y-relevant emergency of problem statements, , or prepared questions ge an emergency plan. ices that provide inpatient hospice must conduct e emergency plan twice per must do the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual onal exercise; or xperiences a natural or ncy that requires activation of n, the hospice is exempt from c required full-scale community sed functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or a facility based functional er drill; or rcise or workshop led by a des a group discussion using a relevant emergency scenario, m statements, directed ared questions designed to	E 039	9		

Facility ID: 921876

If continuation sheet Page 12 of 32

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE					FORM	03/08/2023 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	34G114	B. WING			03/	07/2023
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST CREEK GROUP HOM	ΛE			117 FOREST CREEK DRIVE RALEIGH, NC 27606		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
<ul> <li>hospice's emergen</li> <li>*[For PRFTs at §44 §482.15(d), CAHs at (2) Testing. The [Pf conduct exercises at twice per year. The do the following: <ul> <li>(i) Participate in an is community-base</li> <li>(A) When a community-based function facility-based function (B) If the [PRTF, He actual natural or marequires activation [facility] is exempt for required full-scale of facility-based function (ii) Conduct an and that may include following: <ul> <li>(A) A second full-scale of functional exercises</li> <li>(B) A mock</li> <li>(C) A tabletop of led by a facilitator at discussion, using at emergency scenario statements, directe questions designed plan.</li> </ul> </li> </ul></li></ul>	ergency events and revise the cy plan, as needed. 41.184(d), Hospitals at at §485.625(d):] RTF, Hospital, CAH] must to test the emergency plan e [PRTF, Hospital, CAH] must annual full-scale exercise that d; or unity-based exercise is not annual individual, ional exercise; or ospital, CAH] experiences an an-made emergency that of the emergency plan, the from engaging in its next community based or individual, ional exercise following the ency event. n [additional] annual exercise or de, but is not limited to the cale exercise that is or individual, a facility-based	EC	039			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G114	B. WING			03/0	07/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	IE			117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	[facility's] emergend *[For PACE at §460 (2) Testing. The PA exercises to test the annually. The PACE following: (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functi (B) If the PACE exp man-made emerge the emergency plar engaging in its next based or individual, exercise following the event. (ii) Conduct an years opposite the exercise under para is conducted that m the following: (A) A second full-se community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator and incl using a narrated, cl scenario, and a set directed messages designed to challen (iii) Analyze the PA	Argency events and revise the sy plan, as needed. A.84(d):] CE organization must conduct e emergency plan at least E organization must do the annual full-scale exercise that d; or inity-based exercise is not t an annual individual, onal exercise; or eriences an actual natural or ncy that requires activation of n, the PACE is exempt from required full-scale community facility-based functional ne onset of the emergency additional exercise every 2 year the full-scale or functional agraph (d)(2)(i) of this section ay include, but is not limited to cale exercise that is or individual, a facility based or	E	039			

Facility ID: 921876

If continuation sheet Page 14 of 32

		AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G114	B. WING			03/(	07/2023
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	ΛE			117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	PACE's emergency *[For LTC Facilities (2) The [LTC facility test the emergency including unannoun emergency procedu ICF/IID] must do the (i) Participate in an is community-based (A) When a commu accessible, conduct facility-based functi (B) If the [LTC facility actual natural or marequires activation LTC facility is exem required a full-scale individual, facility-based following the onset (ii) Conduct an add may include, but is (A) A second full-sc community-based of functional exercise; (B) A mock disaste (C) A tabletop exer a facilitator includes narrated, clinically-r and a set of probler messages, or prepar challenge an emerg (iii) Analyze the [LT and maintain docur exercises, and emerged	y plan, as needed. at §483.73(d):] J must conduct exercises to plan at least twice per year, need staff drills using the ures. The [LTC facility, e following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise. ity] facility experiences an an-made emergency that of the emergency plan, the pt from engaging its next e community-based or ased functional exercise of the emergency event. ditional annual exercise that not limited to the following: cale exercise that is or an individual, facility based ; or er drill; or rcise or workshop that is led by s a group discussion, using a relevant emergency scenario, m statements, directed ared questions designed to gency plan. TC facility] facility's response to mentation of all drills, tabletop ergency events, and revise the 's emergency plan, as needed.	EC	039			

If continuation sheet Page 15 of 32

		AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G114	B. WING			03/0	07/2023
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	IE			5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	<ul> <li>(2) Testing. The ICF to test the emergen The ICF/IID must de (i) Participate in an is community-based (A) When a community-based function of the ICF/IID exeman-made emerger the emergency planengaging in its next community-based of functional exercise emergency event.</li> <li>(ii) Conduct an addit may include, but is (A) A second full-sc community-based of functional exercise;</li> <li>(B) A mock disaster (C) A tabletop exercise a facilitator and inclusing a narrated, cli scenario, and a set directed messages, designed to challen (iii) Analyze the ICF/IID's emergence a facilitator and exercises.</li> <li>*[For HHAs at §484 (d)(2) Testing. The Ico test the emergence in the emergence is a nanually. The</li> </ul>	F/IID must conduct exercises acy plan at least twice per year. o the following: annual full-scale exercise that d; or unity-based exercise is not t an annual individual, onal exercise; or. cperiences an actual natural or ncy that requires activation of n, the ICF/IID is exempt from crequired full-scale or individual, facility-based following the onset of the itional annual exercise that not limited to the following: cale exercise that is or an individual, facility-based or r drill; or cise or workshop that is led by udes a group discussion, inically-relevant emergency of problem statements, , or prepared questions ge an emergency plan. F/IID's response to and ation of all drills, tabletop ergency events, and revise the cy plan, as needed. A.102] HHA must conduct exercises icy plan at HHA must do the following: ull-scale exercise that is	EC	039			

		AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G114	B. WING			03/(	07/2023
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HON	1E			117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
PREFIX TAG		SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		DATE
E 039	Continued From pa	ge 16	E (	)39			
		nmunity-based exercise is not t an annual individual,					
	facility-based function	onal exercise every 2 years;					
		experiences an actual natural					
		gency that requires activation lan, the HHA is exempt from					
	engaging in its next community-based c	required full-scale or individual, facility based					
	functional exercise	following the onset of the					
	emergency event. (ii) Conduct an addi	itional exercise every 2 years,					
	opposite the year th	ne full-scale or functional					
	is conducted, tha	agraph (d)(2)(i) of this section it may include, but is not					
		Ill-scale exercise that is					
	functional exercise;						
	(B) A mock disa (C) A tabletop e	aster drill; or exercise or workshop that is					
		nd includes a group narrated, clinically-relevant					
	emergency scenario	o, and a set of problem d messages, or prepared					
	questions designed	to challenge an emergency					
		A's response to and maintain					
		Il drills, tabletop exercises, and and revise the HHA's					
	emergency plan, as						
	*[For OPOs at §486 (d)(2) Testing. The	6.360] OPO must conduct exercises					
		cy plan. The OPO must do the					
	(i) Conduct a paper	-based, tabletop exercise or nnually. A tabletop exercise is					
	workshop at least a	mually. A lable op exercise is					

		AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE SURVEY COMPLETED	
		34G114	B. WING	i		03/(	07/2023
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	ΛE			5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	led by a facilitator a discussion, using a emergency scenari statements, directe questions designed plan. If the OPO ex man-made emerge the emergency plan engaging in its next following the onset (ii) Analyze the OPO documentation of a emergency events, OPO's] emergency *[ RNCHIs at §403. (d)(2) Testing. The exercises to test the must do the followin (i) Conduct a paper least annually. A tal discussion led by a clinically-relevant et of problem statement prepared questions emergency plan. (ii) Analyze the RNH maintain document and emergency events This STANDARD is Based on document facility failed to ensi- mock drill or an anni- conducted and inclu- Emergency Prepared	and includes a group narrated, clinically relevant o, and a set of problem of messages, or prepared d to challenge an emergency speriences an actual natural or ency that requires activation of n, the OPO is exempt from t required testing exercise of the emergency event. O's response to and maintain and revise the [RNHCI's and plan, as needed. 748]: RNHCI must conduct e emergency plan. The RNHCI ng: -based, tabletop exercise at bletop exercise is a group facilitator, using a narrated, mergency scenario, and a set ents, directed messages, or a designed to challenge an HCI's response to and tation of all tabletop exercises, ents, and revise the RNHCI's s needed. s not met as evidenced by: nt review and interviews, the ure a full scale evacuation, mual tabletop activity was	EC	039			

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G114	B. WING _			03/	07/2023
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	1E			117 FOREST CREEK DRIVE ALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039	revealed there was Further review indic documentation abo 2021 or 2022. During an interview	no annual tabletop conducted.	E 03	139			
W 125	have documentation activity.	n detailing a annual tabletop CLIENTS RIGHTS	W 12	25			
	Therefore, the facili individual clients to of the facility, and a including the right to to due process. This STANDARD is Based on record re- interviews, the facili	ity must allow and encourage exercise their rights as clients is citizens of the United States, o file complaints, and the right is not met as evidenced by: eview, observation and ity failed to ensure clients had guardian. This affected 1 of 3 The finding is:					
	had been admitted client's Individual Pr 12/14/22 indicated to guardian. Additiona indicated the client diagnosis of Mild In	i client #4's record revealed he to the home on 11/16/22. The rogram Plan (IPP) dated the client acted as his own I review of the record was 19 years old and had a tellectual Disability, Autism, y history of unexplained sion disorder.					
	liked living in the ho #4 went on the say	on 3/6/23, when asked if he ome he stated, "So-So". Client he was moving back home to a client #4 was asked why he					

If continuation sheet Page 19 of 32

		AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í			(X3) DATE SURVEY COMPLETED	
		34G114	B. WING			03/(	07/2023
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	ΛE			117 FOREST CREEK DRIVE ALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 125	takes the medicatio not know why. Whe my Mom." During an interview that client #4 should due to the fact that the other clients livit interview revealed of he wants to move b During an interview Intellectual Disabilit confirmed client #4 own guardian and t was admitted to the had a conversation client #4 was admitt guardianship but sh INDIVIDUAL PROG CFR(s): 483.440(c) Within 30 days afte interdisciplinary tea assessments or rea supplement the pre prior to admission. This STANDARD is Based on record re facility failed to obta for 1 newly admitted days after admission A. Review on 3/6/2 Program Plan (IPP) was admitted to the	on Invega, he reported he did en asked again he said, "Ask on 3/7/23, Staff B reported d not be living in the home, he is on a "different level' of ng in the home. Additional client #4 has told Staff B that back to Ohio. on 3/6/23, the Qualified ties Professional (QIDP) was currently acting as his his was his status when he home. QIDP revealed that he with client #4's mother when ted to the facility about taking he did not seem interested. GRAM PLAN (3) or admission, the m must perform accurate assessments as needed to diminary evaluation conducted s not met as evidenced by: eview and interviews, the ain needed initial assessments d client (#4) no later than 30 on. The findings are: 23 of client #4's Individual ) dated 12/14/22 revealed he e facility on 11/16/22. Further a revealed he does not have a	W 1		DEFICIENCY)		

If continuation sheet Page 20 of 32

	-	AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G114	B. WING		03/(	07/2023
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	NE		5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 210	Continued From pa	ge 20	W 21	0		
	12/14/22 revealed h on 11/16/22. Furthe	23 of client #4's IPP dated ne was admitted to the facility er of client #4's record ot have an initial visual				
W 216	Supervisor (AS) con have a Social Work examination.		W 21	6		
	include physical dev This STANDARD is Based on record re facility failed to ensu	e functional assessment must velopment and health. s not met as evidenced by: eview and interviews the ure 1 newly admitted clients' al was done within 30 days of ding is:				
	revealed there was examination. Furth	f client #4's current record no current annual physical er review revealed there was when client #4 had his last				
W 217	confirmed client #4 examination.		W 21	7		
	include nutritional s This STANDARD is	e functional assessment must tatus. s not met as evidenced by: eview and interview, the facility				

Facility ID: 921876

If continuation sheet Page 21 of 32

						0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		34G114	B. WING _		03/	07/2023
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	IE		5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 217	Continued From pa	ge 21 f 3 audit clients (#1) nutritional	W 2 <sup>-</sup>	17		
		been updated. The finding is:				
		f client #1's record revealed onal assessment for 2022 or				
W 218	Intellectual Disabilit		W 2 <sup>.</sup>	18		
	CFR(s): 483.440(c)					
	include sensorimoto This STANDARD is Based on record re facility failed to obta	s not met as evidenced by: eviews and interviews, the in a needed sensorimotor ewly admitted client (#4) within				
	Program Plan (IPP) was admitted to the review revealed clie	f client #4's Individual dated 12/14/22 revealed he facility on 11/16/22. Further ent #4 did not have a apy (OT) assessment.				
W 220	Supervisor (AS) con have a OT assessm	GRAM PLAN	W 22	20		
	include speech and This STANDARD is	e functional assessment must language development. s not met as evidenced by: eviews and interviews, the				

Facility ID: 921876

If continuation sheet Page 22 of 32

		AND HUMAN SERVICES			FORM	03/08/2023 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	DELE CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		34G114	B. WING		03/	07/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HOM	1E		5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 220	Continued From par facility failed to ensu (#4) received his init assessments within finding is: Review on 3/6/23 of Program Plan (IPP) was admitted to the review revealed clies speech/language as During an interview confirmed client #4 speech/language as INDIVIDUAL PROG CFR(s): 483.440(c) The comprehensive include auditory fun This STANDARD is Based on record ref facility failed to ensu for 1 newly admitted 30 days of admission Review on 3/6/23 of Program Plan (IPP) client was admitted Further review reve documentation india physical.	age 22 ure 1 newly admitted client itial speech/language a 30 days of admission. The f client #4's Individual ) dated 12/14/22 revealed he e facility on 11/16/22. Further ent #4 did not have a ssessment. To n 3/7/23, the facility's nurse did not have a ssessment. GRAM PLAN (3)(v) e functional assessment must for a physical examination d client (#4) was done within on. The finding is: f client #4's Individual ) dated 12/14/22 stated the to the facility on 11/16/22. ealed there was no cating client #4 had received a	W 220	DEFICIENCY)		
	confirmed client #4'	on 3/7/23, the facility's nurse 's physical examination was days of his admission to the				
	During an interview	on 3/7/23, the Area				

If continuation sheet Page 23 of 32

		AND HUMAN SERVICES			FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		34G114	B. WING		03/	07/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST	CREEK GROUP HON	ΛE		5117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 221	Supervisor (AS) rev COVID-19 in late 20 documentation exp	ige 23 vealed the facility had 022; but there was no laining why client #4's physical ot conducted on time.	W 221			
W 249	PROGRAM IMPLE CFR(s): 483.440(d)		W 249	)		
	formulated a client's each client must re- treatment program interventions and se and frequency to su	rdisciplinary team has s individual program plan, ceive a continuous active consisting of needed ervices in sufficient number upport the achievement of the d in the individual program				
	Based on observat interviews, the facili clients (#1) received treatment program interventions and so Individual Program	s not met as evidenced by: tions, record reviews and ity failed to ensure 1 of 3 audit d a continuous active consisting of needed ervices as identified in the Plan (IPP) in the area of ipment. The finding is:				
	- 7/23, client #1 was regular glasses. Fu client #1 was eating	oservations in the home on 3/6 s observed drinking from urther observations revealed g from a scoop plate and using h a red foam handle on the				
	revealed his adaptiv	client #1's IPP dated 8/12/22 ve equipment when eating is a angled spoon and fork, and				

If continuation sheet Page 24 of 32

		AND HUMAN SERVICES			FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
34G114		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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 249	Continued From pa	ge 24	W 249			
W 263	Intellectual Disabilit confirmed client #1 plate, grip angled s during meals.	on 3/6/23, the Qualified ies Professional (QIDP) should be using his divided poon and fork, and desk mug ORING & CHANGE (3)(ii)	W 263	3		
	are conducted only consent of the clien minor) or legal guar This STANDARD is Based on record re failed to ensure res conducted with the	s not met as evidenced by: eview and interview, the facility trictive programs were only written informed consent of a s affected 3 of 3 audit clients				
	surveyor noticed that	s in the home on 3/6/23, the at there was a lock on the er observations revealed staff unlock the pantry.				
	Program Plan (IPP)	3 of client #1's Individual ) dated 8/12/22 did not include llowing the pantry to be locked				
	12/14/22 did not inc	3 of client #4's IPP dated clude a signed consent to be locked in the home.				
		23 of client #5's IPP dated de a signed consent allowing ked in the home.				

If continuation sheet Page 25 of 32

		AND HUMAN SERVICES				FORM	03/08/2023 APPROVED 0938-0391
		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
34G114			B. WING		03/(	07/2023	
NAME OF PROVIDER OR SUPPLIER				S	TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST CREEK GROUP HOME					117 FOREST CREEK DRIVE ALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
W 263	During an interview the pantry is always the home from takin During an interview Intellectual Disabilit confirmed the pantr the fact clients #1, # consents allowing for NURSING SERVIC CFR(s): 483.460(c) Nursing services m other members of t appropriate protect measures that inclu training clients and health and hygiene This STANDARD is Based on observat interview, nursing s staff were sufficient face masks and of visitors. This potent #2, #3, #4 and #5) for findings are: A. During observat when the surveyor the surveyors' temp time was the survey temperature. The so on 3:31pm, and the until 4:18pm when the Qualified Intellectual	on 3/6/23, Staff A confirmed s locked to prevent clients in ing food. To on 3/6/23, the Qualified dies Professional (QIDP) ry should not be locked, due to #4 and #5 do not have signed or it to be locked. ES (5)(i) ust include implementing with he interdisciplinary team, ive and preventive health ude, but are not limited to staff as needed in appropriate methods. s not met as evidenced by: tions, documentation and ervices failed to ensure that dily trained in the wearing of taking of temperatures of tially effected all clients (#1, residing in the facility. The tions in the home on 3/6/23 entered the home at 9:33am, berature was not taken. At no yor asked to take their surveyor reentered the home air temperature was not taken the surveyor asked the al Disabilities Professional bout the protocol for taking the	W 2				

Facility ID: 921876

If continuation sheet Page 26 of 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SUR COMPLET B. WING         NAME OF PROVIDER OR SUPPLIER       34G114       B. WING       03/07/20         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       03/07/20         FOREST CREEK GROUP HOME       STREET ADDRESS, CITY, STATE, ZIP CODE       5117 FOREST CREEK DRIVE RALEIGH, NC 27606       5117 FOREST CREEK DRIVE RALEIGH, NC 27606         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL       ID PREFIX       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE       COM	OMB NO. 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         FOREST CREEK GROUP HOME       5117 FOREST CREEK DRIVE         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)	(X3) DATE SURVEY COMPLETED
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     COM	03/07/2023
FOREST CREEK GROUP HOME       RALEIGH, NC 27606         (X4) ID       SUMMARY STATEMENT OF DEFICIENCIES       ID       PROVIDER'S PLAN OF CORRECTION         PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE       COM         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE       COM	DE
PREFIX TAG         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         PREFIX TAG         (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE         COM	
	SHOULD BE COMPLÉTION
W 340       Continued From page 26       W 340         During an interview on 3/6/23, the QIDP revealed the surveyors' temperature should have been taken when they first entered the home.       W 340         B. During observations in the home on 3/6/23 when the surveyor entered the home at 9:33am, the three staff duot put on face masks. The three staff duot put on face masks until the surveyor began asking questions.       W 340         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 use tal limes while they are working in the home.         During an interview on 3/7/23 at 8:12am, Staff D pulled up their face masks.       During an interview on 3/7/23, the Area Supervisor stated staff are to wear face masks.         During an interview on 3/7/23, the Area Supervisor stated staff are to wear face masks.       During an interview on 3/7/23, the Area Supervisor stated staff are to wear face masks.         During an interview on 3/7/23, the Area Supervisor stated staff are to wear face masks.       During an interview on 3/7/23, the Area Supervisor stated staff are to wear face masks.	

If continuation sheet Page 27 of 32

		E & MEDICAID SERVICES				<u>). 0938-039</u> TE SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		
		34G114	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	•	S	TREET ADDRESS, CITY, STATE, ZIP COI	DE	
FOREST	CREEK GROUP HO	ME	-	117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
W 351	Continued From pa	age 27	W 351			
W 351	· ·	E DENTAL DIAGNOSTIC	W 351			
	include a complete examination, using to properly evaluate than one month aff	ental diagnostic services e extraoral and intraoral all diagnostic aids necessary e the client's condition not later ter admission to the facility nation was completed within ore admission).				
	Based on record r facility failed to ens	is not met as evidenced by: eview and interviews, the sure a dental examination for 1 ent (#4) was done within 30 The finding is:				
	Program Plan (IPP client was admitted Further review reve	of client #4's Individual ) dated 12/14/22 stated the d to the facility on 11/16/22. ealed client #4's dental onducted on 2/3/23.				
	confirmed client #4	y on 3/7/23, the facility's nurse y's dental examination was not is of his admission to the				
W 441	Supervisor (AS) re COVID-19 in late 2 documentation exp examination was n	v on 3/7/23, the Area vealed the facility had 2022; but there was no plaining why client #4's dental ot conducted on time.	W 441			

If continuation sheet Page 28 of 32

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM	APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		34G114	B. WING _		03/07/2023				
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
FOREST	CREEK GROUP HOM	A F		5117 FOREST CREEK DRIVE					
TOREOT	ST CREEK GROUP HOME			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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	OULD BE COMPLETION				
W 441	Continued From pa	ge 28	W 44	1					
W 455	Based on the revie interviews, the facili evacuation drills we This potentially affe #4, #5 and #6) resid is: Review on 3/6/23 or revealed revealed th 2022. During an interview Intellectual Disabilit confirmed there we 2022. INFECTION CONT CFR(s): 483.470(I)( There must be an a prevention, control, and communicable This STANDARD is Based on observat failed to ensure a sa provided to avoid tra infection and preven cross-contamination	s not met as evidenced by: w of the fire drill reports and ity failed to ensure fire ere conducted at varied times. acted all the clients (#1, #2, #3, ding in the home. The finding f the facility's fire drills here were no fire drills held in f on 3/6/23, the Qualified ies Professional (QIDP) re no fire drills conducted in ROL (1) active program for the and investigation of infection diseases. s not met as evidenced by: tions and interviews, the facility anitary environment was ansmission of possible	W 45	5					
	is: During breakfast ob 3/7/23 at 7:49am, c	oservations in the home on lient #4 used the same spoon tter that he had used to eat his							

If continuation sheet Page 29 of 32

		AND HUMAN SERVICES			FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
34G114		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	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
W 455 W 460	During breakfast ob 3/7/23 at 8:06am, a client to scoop pear client #4 had put his observations reveal with peanut butter. During an interview peanut butter shoul after client #4 put h During an interview spoon he used to se the same one that H During an interview Intellectual Disabilit confirmed the pean thrown away after of FOOD AND NUTRI CFR(s): 483.480(a) Each client must re well-balanced diet in specially-prescribed This STANDARD is Based on observat interviews, the facilit received a nourishin including modified s prescribed. This af The finding is: During breakfast ob 3/7/23 at 7:41am, c	beservations in the home on a staff person assisted another nut butter from the same jar is spoon in. Further led the client then ate his toast on 3/7/23, Staff D stated the d have been thrown away is spoon in it. on 3/7/23, client #4 stated the coop the peanut butter was ne used to eat his cereal with. on 3/7/23, the Qualified ies Professional (QIDP) but butter should have been client #4 put his spoon in it. TION SERVICES 0(1) ceive a nourishing, ncluding modified and d diets. s not met as evidenced by: tions, record reviews and ity failed to ensure each client ng, well balanced diet specially prescribed diet as fected 1 of 3 audit clients (#1).	W 455	5		
	3/7/23 at 7:41am, c					

If continuation sheet Page 30 of 32

CENTERS FOR MEDICARE & MEDICAID SERVICES         STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING         34G114       B. WING	(X3) DATE		
34G114 B. WING		(X3) DATE SURVEY COMPLETED	
	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 TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGID PREFIX PREFIX TAGPROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY MUST BE PRECEDED BY FULL TAGID PREFIX CROSS-REFERENCED TO THE APP 	ULD BE	(X5) COMPLETION DATE	
W 460       Continued From page 30       W 460         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.       W 460         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 kinfe 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 477         W 477       MENUS       W 477         VW 477       MENUS       W 477         During an interview on 3/6 - 7/23, no updated menus were 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 wire available for review.			

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	03/08/2023 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
34G114		B. WING			03/07/2023		
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
FOREST CREEK GROUP HOME					117 FOREST CREEK DRIVE RALEIGH, NC 27606		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
W 477	had been available asked how they know indicated they use of Further interview we either the Nutritioni drop off the update During an interview Supervisor (AS) co home have not beet	interview indicated no menus for several months. When ow what to cook, the staff food available in the home. ith Staff A and Staff B revealed st or the Site Supervisor would d menus. on 3/7/23, the Area nfirmed the menus for the en updated. Additional it is the responsibility of the	₩ 2	177			

Facility ID: 921876

If continuation sheet Page 32 of 32