STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G336	A. BUILDING _____ B. WING _____	C 09/27/2022

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

(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 000	INITIAL COMMENTS A complaint survey was completed on 9/27/22 for intake #NC00192963. The allegation was substantiated and deficiencies were cited as a result of the investigation.	W 000	Preparing and execution of this Plan of Correction does not constitute admission of agreement by the provider or the truth of facts alleged or conclusion set forth in the statement of deiciencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law.	
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure staff were trained on procedures for assuring client safety and supervision during behaviors for 1 of 2 audited clients (#6). The finding is: Record review on 9/27/22 of an in-service attendance sheet for client #6's supervision protocol on 9/1/22 revealed that effective immediately, he must be visually supervised at all times during waking hours. He may have alone time in his private bedroom if he chooses to. During these times, staff must conduct fifteen (15) minute checks to ensure safety. Staff A who was assigned to client #6 on 8/31/22, the day he left the home unsupervised, was not in attendance for the in-service. Staff B and Staff C were not identified as receiving training on the supervision protocol. Interview on 9/27/22 with the Program Director (PD) revealed that the Home Manager (HM) told her that she verbally trained Staff A on 9/1/22 after the team met to revise client #6's supervision plan, but she failed to document her	W 189	W189 GHM will in-service staff on the supervision protocols for Client #6 to ensure client safety. Plan to prevent reoccurrance: Monitoring will be conducted by the QP, ADM, and QA Specialist during NEO and conducting chart audits.	10/31/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Cynthia B. Stevens	IDD Facility Administrator	10/19/2022

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 189	Continued From page 1 actions. The PD also revealed that she did not have any written evidence that new employees, Staff B and Staff C were trained on these guidelines.	W 189		
W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all data relative to hourly supervision to prevent elopement was documented. This affected 1 of 2 audited clients (#6). The finding is: Record review on 9/27/22 of the Hourly Interval Behavior Charts (HIBC) for client #6 from 8/29/22 to 9/26/22 revealed consistent gaps in daily data collection. Record review on 9/27/22 of an in-service attendance sheet for client #6's supervision protocol on 9/1/22 revealed that effective immediately, he must be visually supervised at all times during waking hours. He may have alone time in his private bedroom if he chooses to. During these times, staff must conduct fifteen (15) minute checks to ensure safety. Interview on 9/27/22 with the Psychiatrist revealed that staff were expected to record every hour on the HIBC either no behavior occurred or	W 252	W252 GHM will inservice staff on proper documentation specific to individual program plans and client supervision protocol. Plan to prevent reoccurranve: Monitoring will be conducted by QP and ADM during monthly staff meetings.	10/31/2022

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W 252	Continued From page 2 identified what behavior happened and give more detail on the ABC data sheet. Interview on 9/27/22 with the Program Director (PD) acknowledged that client #6 eloped from the facility on 8/31/22 after lunch and was found by a neighbor on their street. The PD revealed that the home manager and qualified intellectual disability professional (QIDP) were responsible for reviewing the data sheets. The PD was not aware that the data was not being collected every hour.	W 252		