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

PRINTED: 12/08/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G336	A. BUILDING ______ B. WING ______	12/07/2022

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

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W 120	SERVICES PROVIDED WITH OUTSIDE SOURCES CFR(s): 483.410(d)(3) The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based interview and record review, the facility failed to assure consistent communication with the public school system for 2 of 5 audit clients (#4 and #6) was sufficient to ensure needs of the clients' were being met. The findings are: A. Interview on 12/7/22 with the public school teacher for client #4 revealed there was not consistent communication with the facility regarding absences from school for physician appointments. On 12/7/22 client #4 had an outside medical appointment and remained at the facility. Further interview with the public school teacher stated she had not been notified that he would not be at school on 12/7/22. The teacher for client #4 further stated she was often not notified of other absences but would depend on client #4 to tell her why he was out of school on a particular day. Client #4's teacher stated that she had not been invited to attend his individual program plan (IPP) meeting on 1/26/22. Additional interview revealed she was not certain who the contact person at the facility was for client #4. Review on 12/7/22 of client #4's IPP revealed there was no documentation that client #4's teacher's input was provided for his IPP meeting on 1/27/22. Interview on 12/7/22 with the qualified intellectual disabilities professional (QIDP) confirmed she had not visited client #4's school and had just	W 120	Preparation 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 deficiencies. The Plan of correction is prepared and/or executed solely because it is required by the provision of state and federal law. W120 QP will notify school teachers of resident appointments prior to appointments and document such notification. QP will send invite to teachers to participate in residents' annual PCP meetings. A copy of the invite will will be filed in resident charts. GHM will ensure that Client #6 has appropriate number of incontinent products sent to school on a daily bases. QP and GHM will review and respond, as appropriate, to any request from the school in a timely manner. Plan to Prevent Re-occurrence: Monitoring will be conducted by the Administrator and QA Specialists during monthly CQI meetings.	2/5/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia B. Stevens
TITLE: Administrator
(X6) DATE: 12/23/2022

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.

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W 120	Continued From page 1 sent an email to the teacher in reference to his absence on 12/7/22. B. Interview on 12/7/22 with the public school teacher for client #6 revealed since October 2022 she had ongoing problems with the facility not sending adequate numbers of incontinent products to school for client #6. Further interview revealed she had emailed the facility to let them know client #6's bookbag was broken and that she needed additional incontinent products for client #6. The teacher stated when she did not receive a response from the facility, she located an additional bookbag at the school and sent it home with client #6 and that she had to borrow incontinent products from the school supply room. Additional interview revealed she had not been invited to client #6's IPP conference on 9/22/22 or asked for input. Review on 12/7/22 of client #6's IPP revealed there was no documentation that client #6's teacher's input was provided for his IPP meeting on 9/22/22. Interview on 12/7/22 with the QIDP confirmed she had not visited client #6's school and that she had received emails from the teacher regarding the incontinent products and broken bookbag. She also acknowledged the teacher had not attended client #6's IPP meeting and that her input was not provided prior to the meeting.	W 120		
W 126	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(4) The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them	W 126		

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W 126	Continued From page 2 to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 5 audit clients (#5) was involved in formal money management training. The finding is: Review on 12/6/22 of client #5's individual program plan (IPP) dated 2/9/22 revealed he had the formal training objectives: Will decrease disruptive behavior as evidenced by .05 target behaviors or less for 8/12 consecutive months, complete steps in showering with 90% accuracy for 3 consecutive months, will brush his teeth without prompting with 90% accuracy for 3 consecutive months, identify items to prepare for meals with 70% accuracy for 3 consecutive months and set washing machine controls with 80% accuracy for 3 consecutive months. There was no training identified in the area of money management. Review on 12/7/22 of client #5's adaptive behavior inventory dated 4/30/22 revealed all areas of money management such as presenting money to a cashier, waiting for change during a purchase were marked, "NA" (not applicable). Interview on 12/7/22 with the qualified intellectual disabilities professional (QIDP) revealed client #5 does not currently have any formal training in the area of money management.	W 126	W126 HS will assess Client #5 to determine his functioning level as it relates to money management to determine the appropriateness of a formal money management goal. Plan to Prevent Re-occurrence: QP will monitor closely to ensure compliance and the appropriateness of Client 5's training objectives.	2/5/2023
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.	W 130		

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W 130	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations, record review and confirmed by interviews with staff, the facility failed to provide privacy to 2 of 5 audit clients (#2 and #6) during personal care and grooming. The finding is: During observations in the facility on 12/7/22 at 5:45am, staff D woke client #6 up and took him to the bathroom in client #2's bedroom. Client #6 was naked and staff D assisted him to his bathroom to start his bath. The bedroom door remained open, leaving client #6 visible from the hallway. At 5:55am, staff D woke client #2 and assisted him to the bathroom adjacent to his bedroom. Staff D undressed client #2 in client #6's bedroom leaving the bedroom door open. Staff D then took client #2 into the bathroom to start his bath. The bedroom door remained open, leaving client #2 visible from the hallway. Interview on 12/7/22 with staff C revealed she was uncertain whether clients #2 and #6 had bathrobes. Review on 12/7/22 of client #2's adaptive behavior inventory (ABI) dated 6/10/22 revealed client #2 needs staff assistance to protect his privacy during bathing and dressing. Review on 12/7/22 of client #6's ABI dated 8/31/22 revealed he requires staff assistance with toileting, dressing, as well as protecting his privacy during self care tasks. Interview on 12/7/22 with the qualified intellectual disabilities professional (QIDP) and program director revealed both staff C and D have been trained and should assist clients #2 and #6 in	W 130	W130 QP will in-service GHM and staff client rights and the importanceof protecting resident privacy. GHM will ensure all residents have bathrobes to use daily. GHM will re-inservice staff on residents' needs as it relates to bathing, dressing and self-care skills. Plan to Prevent Re-occurrence: Monitoring will be conducted by the QP, HS and/or Administrator through random observations.	2/5/2023

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W 130	Continued From page 4 protecting their privacy during self care tasks.	W 130		
W 288	MGMT OF INAPPROPRIATE CLIENT BEHAVIOR CFR(s): 483.450(b)(3) Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure interventions to manage behaviors for 1 of 5 audit clients (#2) were part of a formal active treatment plan. The finding is: During observations of the medication administration pass on 12/7/22 at 7:05am, a grooming kit was noted to sit on a cabinet with client #2's name on it containing toothpaste, deodorant, soap, comb and a brush. Immediate interview with staff D on 12/7/22 confirmed this grooming kit belonged to client #2 and that he would often inappropriately empty contents of soap, toothpaste and shampoo in his bedroom. Review on 12/7/22 of client #2's individual program plan (IPP) dated 6/15/22 revealed he has a formal behavior support program but there is no mention of client #2 emptying personal hygiene items inappropriately in his IPP or that his grooming items are restricted from his bedroom. Review on 12/7/22 of client #2's behavior support program (BSP) dated 9/13/22 lists his target behaviors as: aggression, self-injury, uncooperative behavior and disruptive behavior.	W 288	W288 QP will work with the Psychologist to discuss Client #2's behavior of inappropriately emptying his personal hygiene items in his bedroom, the need to identify this as a target behavior and the appropriateness of restricting these items from his bedroom. Psychologist will update Client #2's BSP as appropriate to include restriction of personal hygieneitems. appropriate to include restriction of personal hygiene items. Plan to Prevent Re-occurrence: Monitoring will be conducted by the Administrator and QA Specialists during monthly CQI meetings. Monitoring will be conducted by the Administrator	2/5/2023

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W 288	Continued From page 5 There is no mention of client #2 emptying personal hygiene items inappropriately in his BSP or that his grooming items are restricted from his bedroom. Interview with the shift person on 12/7/22 revealed client #2's grooming kit is kept near the medication room because he inappropriately empties items if not supervised. Further interview revealed she was not certain whether this information was included in client #2's BSP. Interview on 12/7/22 with the qualified intellectual disabilities professional (QIDP) confirmed this information regarding client #2's grooming kit being kept outside of his bedroom is not included in client #2's IPP or BSP.	W 288		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations and interviews, nursing services failed to assure staff were adequately trained in appropriate procedures for following mask guidance in conjunction with preventing the spread of COVID-19 for 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The findings are: During interview on 12/6/22 the qualified intellectual disabilities professional (QIDP) and the program director confirmed the facility had recently made a decision to drop their mandate	W 340	W 340 LPN will re-inservice staff on the COVID protocol as it relates to the mask mandate and the use of masks in the facility. Plan to Prevent Re-occurrence: Monitoring will be conducted by the QP, LPN and/or Administrator through random observations to ensure compliance.	2/5/2023

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W 340	Continued From page 6 about requiring the use of masks in their facilities. Both the QIDP and program director were made aware by the surveyor and the ICF/IID Branch manager of the current Centers for Disease Control (CDC) recommendations regarding the wearing of masks in healthcare facilities dated 9/23/22. Subsequent interview on 12/6/22 with the program director revealed the facility was amending their decision to drop masks and asked direct care staff to continue to wear masks until the CDC came out with updated requirements effective 12/6/22. During observations on 12/7/22 at 5:50am-6:25am, staff C and staff D were observed not to wear facial masks with all 6 clients in the facility during bathing, dressing and meal preparation activities. The lead direct care staff (DCS) came into work and asked both staff to put on facial masks about 6:15am, however neither staff put on a facial mask. When the program director came into the facility, she asked both staff C and staff D to put on facial masks. Additional interview on 12/7/22 with the program director confirmed staff C and staff D were not following facility guidelines on the morning of 12/7/22.	W 340		
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.	W 460		

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W 460	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure 1 of 5 audit clients (#6) was provided his specially-prescribed diet. The finding is: During observations of the supper meal in the facility on 12/6/22 at 6:45pm staff A assisted client #6 to serve turkey breast, mixed vegetables, boiled potatoes and bread onto his plate. Client #6's turkey pieces were cut up by staff A but were in excess of an inch in size. Client #6's bread was also in excess of an inch in size. Client #6 picked up pieces of bread and tore it into pieces. Review on 12/6/22 of client #6's nutritional evaluation dated 9/22/22 revealed client #6 is prescribed a regular diet with his food cut into size pieces and served on a sectional plate. Review on 12/7/22 of client #6's adaptive behavior inventory (ABI) dated 8/31/22 revealed he needs assistance with cutting with a knife but has independent dining skills. Interview on 12/7/22 with the qualified intellectual disabilities professional (QIDP) and the program director revealed bite sized pieces should be smaller than 1/2 inch in size.	W 460	W 460 LPN will re-inservice staff on Client #6's prescribeddiet and the importance of his food being cut into appropriate sizes. HS will review ABI for accuracy and to ensure that Client #6's true level of independence are reflected in the ABI. HS will revise the ABI as appropriate and in-service staff on any necessary revisions. Plan to Prevent Re-occurrence: Monitoring will be conducted by the QP, LPN and/or Administrator through random observations to ensure compliance.	2/5/2023