	-	ID HUMAN SERVICES MEDICAID SERVICES					APPROVED 0. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>		CONSTRUCTION	(X3) DATE	
		34G192	B. WING			05/	29/2024
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
FORSYTH	GROUP HOME #2				60 BELEWS CREEK ROAD ELEWS CREEK, NC 27009		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 159	integrated, coordinate qualified intellectual of This STANDARD is r Based on record revi Qualified Intellectual I (QIDP) failed to ensur (PCP) for 3 of 3 audit were sufficiently monifor for program revisions regarding expired obj A. Review on 5/28/24 1/17/24 revealed 3 tra 1. By 3/15/23, client # washing machine to of verbal assistance for periods (start date 3/2 of the record did not r regarding the objectiv 2. By 11/1/22, client # activities to work on w consecutive review per additional review of th progress notes regard 3. By 3/10/23, client #	ectives. The findings are: of client #3's PCP dated aining objectives: 43 will be able to operate a do his laundry with 90% two consecutive review 15/22). An additional review reveal any progress notes re. 43 will choose between two with 90% accuracy for two eriods (start date 5/1/21). An he record did not reveal any ding the objective. 43 will identify various curacy for two consecutive	W 1	59	DEFICIENCY)		
	review of the record of notes regarding the of Interview on 5/29/24 revealed that the PCF	date 3/15/22). An additional lid not reveal any progress bjective. with the QIDP by phone P objectives were the most ed that she had not reviewed					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 06/05/2024

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES			FC	TED: 06/05/2024 DRM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED	
		34G192	B. WING			05/29/2024
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE,	, ZIP CODE	
FORSYTH	GROUP HOME #2			460 BELEWS CREEK ROAD ELEWS CREEK, NC 2700	9	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
W 159	<ul> <li>expired objectives to a modification.</li> <li>B. Review on 5/28/24 12/7/23 revealed 2 transition of the consecutive review performation of consecutive review performation of the consecutive review of the revealed that the PCF current. QIDP revealed the transmetting expired objectives to the consecutive of the secure of the revealed 3 transmetting the transmetter of the revealed the the revealed the performance of the revealed the transmetter of the revealed 3 transmetter of the revealed the the performance of the revealed the performance of the revealed the transmetter of the revealed the performance of the performance of</li></ul>	ng regarding client #3's determine revisions or e of client #4's PCP dated aining objectives: #4 will be able to state his with 100% accuracy for two eriods (start date 11/28/22). of the record did not reveal egarding the objective. #4 will eat slowly with 90% secutive review periods An additional review of the any progress notes re. with the QIDP by phone P objectives were the most ed that she had not reviewed ng regarding client #4's determine revisions or e of client #6's PCP dated aining objectives: #6 will wipe the table after a endence for two consecutive date 3/10/22). An additional did not reveal any progress	W 159			
	washing machine to d verbal assistance for	to will be able to operate to his laundry with 90% two consecutive review 10/22). An additional review				

Facility ID: 921880

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 06/05/2024 M APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE	E SURVEY PLETED
		34G192	B. WING		05	/29/2024
NAME OF PF	ROVIDER OR SUPPLIER		ę	STREET ADDRESS, CITY, STATE,	ZIP CODE	
FORSYTH	GROUP HOME #2			460 BELEWS CREEK ROAD BELEWS CREEK, NC 27009	)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
W 159 W 253	of the record did not r regarding the objectiv 3. By 5/11/23, client # change for \$1.00 with consecutive review pe An additional review of any progress notes re Interview on 5/29/24 of revealed that the PCF current. QIDP revealed or held a team meetine expired objectives to of modification. PROGRAM DOCUME CFR(s): 483.440(e)(2) The facility must docu are related to the clien and assessments. This STANDARD is r Based on observation interviews, the facility significant event, spect touching/personal spac (#4) to determine if th requires a tracking too possible revision to cl Plan (BSP) and Person The finding is: During observations a	reveal any progress notes re. 66 will be able to make a 95% accuracy for two eriods (start date 5/11/22). of the record did not reveal egarding the objective. with the QIDP by phone P objectives were the most ed that she had not reviewed ag regarding client #6's determine revisions or ENTATION 2) ument significant events that nt's individual program plan not met as evidenced by: ns, record review and failed to document a cifically inappropriate ace affecting one audit client te undocumented behavior ol, an IDT meeting or lient #4's Behavioral Support on Centered Plan (PCP).	W 159		JENCY)	
	inappropriately (touch	ering two surveyors' ouching both surveyors ning waist, shoulders, chest, separate times. At no point				

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	-	D HUMAN SERVICES				FORM	06/05/2024 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				0. 0938-0391 SURVEY LETED
		34G192	B. WING			05/2	29/2024
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
FORSYTH	GROUP HOME #2			8460 BELEWS CREEK RC BELEWS CREEK, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
W 253	Record review on 5/29 dated 12/7/23 and BS one target behavior of (refuse reasonable re- review revealed no do inappropriate touching) Interview on 5/29/24 w #4 frequently exhibit b personal space and in Further interview with #4"s BSP only states target behavior and do inappropriate touching interview with Staff F document the episode redirect client #4. Interview on 5/29/24 w acknowledged client # touching/personal space interview with the faci there were no IDT me regarding inappropria and that staff should r PROGRAM MONITO	becumenting these g/personal space episodes. 9/24 of client #4's PCP 6P dated 11/15/23 revealed f physical aggression quest by staff). Further boumentation regarding g/personal space. With Staff F revealed client behaviors of entering happropriate touching daily. Staff F revealed that client physical aggression as a bes not include g/personal space. Continued revealed staff did not es and were told just to with the facility administrator #4's inappropriate ace episodes. Further lity administrator revealed betings or formal goals te touching/personal space redirect client #4. RING & CHANGE	W 25				
	monitor individual pro- inappropriate behavio in the opinion of the c client protection and r	d review, approve, and grams designed to manage or and other programs that, ommittee, involve risks to ights. not met as evidenced by:					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/05/2024 APPROVED D. 0938-0391
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,			(X3) DATE SURVEY COMPLETED	
		34G192	B. WING			05/	29/2024
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
FORSYTH	GROUP HOME #2				460 BELEWS CREEK ROAD		
				<u> Б</u>	ELEWS CREEK, NC 27009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 262	Continued From page	e 4	w	262			
	interviews, the facility	failed to ensure that					
	restrictive techniques	and behavior support plans					
		d and reviewed annually by					
		nmittee (HRC) for 5 of 6 and #5). The findings are:					
	(#1, #2, #3, #4)	and #5). The infulfigs are.					
	Observations through	out the recertification survey					
		5/29/24 revealed exterior					
		as staff and surveyors					
	entered and exited the	e group home.					
	A. Review of client 1'	's records on 5/29/24					
	revealed a signed cor	nsent dated 5/10/24 by the					
		t door alarms. Continued					
		consents for exit door					
	alarms were reviewed	d or approved by the HRC.					
	B. Review of client 2's	s records on 5/29/24					
	revealed a signed cor	nsent dated 3/18/24 by the					
		t door alarms. Continued					
		consents for exit door					
	alarms were reviewed	d or approved by the HRC.					
	C. Review of client 3's	s records on 5/29/24					
	-	nsent dated 5/10/24 by the					
	-	t door alarms. Continued					
		consents for exit door					
		d or approved by HRC.					
		ed a behavior support plan Subsequent review of the					
		e of behavioral medications.					
		not reveal consents were					
	reviewed or approved	I by the HRC.					
	D. Review of client 4's	s records on $5/20/24$					
		nsent dated 3/26/24 by the					
	-	t door alarms. Continued					
		consents for exit door					
	alarms were reviewed	d or approved by the HRC.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	2: 06/05/2024 1 APPROVED 2: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY
		34G192	B. WING			05/2	29/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STA	TE, ZIP CODE	_	
FORSYTH	GROUP HOME #2		8	460 BELEWS CREEK ROA	D		
1 onor m			E	BELEWS CREEK, NC 27	009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
W 262	Continued From page	5	W 262				
W 263	psychotic medications revealed a signed cor legal guardian. Further consents were review Interview with the faci revealed that updated could not be located of interview revealed HF for all clients should be the HRC annually. PROGRAM MONITO CFR(s): 483.440(f)(3) The committee should are conducted only w consent of the client, minor) or legal guardi This STANDARD is r Based on observation interviews, the facility support plans (BSP) w by the legal guardians finding is: Review of client 3's re behavioral medication reveal consents were legal guardian. Interview with the faci revealed that updated	d 1/1/24 to include the use of s. Continued review hsent dated 3/4/24 by the er review did not reveal red or approved by the HRC. lity administrator on 5/29/24 d signed consent forms during the survey. Continued RC limitation consent forms be updated and signed by RING & CHANGE ((ii) d insure that these programs ith the written informed parents (if the client is a an. not met as evidenced by: ns, record review and failed to ensure behavior were reviewed and approved s for 1 of 6 clients (#3). The ecords on 5/29/24 revealed a	W 263				

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	OF DEFICIENCIES	MEDICAID SERVICES		CONSTRUCTION		O. 0938-039
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,			E SURVEY IPLETED	
		34G192	B. WING		0	5/29/2024
NAME OF PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
ORSYTH	GROUP HOME #2			460 BELEWS CREEK ROAD ELEWS CREEK, NC 27009		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
W 263	interview revealed HI	e 6 RC limitation consent forms be updated and signed by	W 263			
W 440	the legal guardian an EVACUATION DRILL CFR(s): 483.470(i)(1	S	W 440			
	This STANDARD is Based on review and to ensure fire evacual least quarterly for ear affected all clients (# residing in the home.	-				
	May 2023-April 2024 drills documented: 2nd Quarter- June 20	f the facility's fire drills from revealed there were no fire 023 3rd shift 23 1st shift and August 2023				
W 454	Intellectual Disabilitie confirmed there were		W 454			
		vide a sanitary environment transmission of infections.				
	Based on observation failed to ensure staff hand washing and to environment to preve	not met as evidenced by: ons and interview, the facility and clients used proper ensure a sanitary ent cross contamination. This ffect all clients (#1, #2, #3,				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/05/2024 APPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G192	B. WING			05/	29/2024
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
FORSYTH	GROUP HOME #2				8460 BELEWS CREEK ROAD BELEWS CREEK, NC 27009		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
W 454	A. Observations on 5/ mealtime revealed clip prompted by staff to s Continued observatio prompted by staff to p on the dining tables. If revealed staff did not dining tables first. Suf revealed client #4 tou several times in betwe utensils on the dining prompted client #4 to touching the plates ar Interview on 5/29/24 of revealed client #3 and prompted to clean the hands prior to and in 1 B. Observations on 5/ mealtime revealed staff the dining tables. Cor revealed staff did not tables prior to him pla utensils. Further obse sat at the dining table over the table settings revealed staff asked of hands but at no point settings from the table	home. The findings are: (28/24 during the dinner ent #3 and client #4 were set the two dining tables. Ins revealed client #3 was place the cups and napkins Further observations prompt clients to clean the posequent observations ched the bottom of his sock een setting the plates and tables. At no point did staff wash his hands prior to nd the utensils. with the facility administrator d client #4 should have been a tables and wash their between mealtimes. (29/24 during the breakfast aff prompted client #2 to set titinued observations prompt client #2 to wipe the cing down the cups and ervations revealed client #2 and sneezed three times s. Subsequent observations client #2 to rewash his did staff remove the table e after client #2 sneezed. with the facility administrator		454			
W 473	revealed staff should	have prompted client #2 to the table after sneezing.	w	473	3		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 06/05/2024 APPROVED D. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G192	B. WING			05/	29/2024
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
FORSYTH	GROUP HOME #2				8460 BELEWS CREEK ROAD BELEWS CREEK, NC 27009		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
W 473	Continued From page	8	w	473	3		
	This STANDARD is r Based on observation failed to ensure food v appropriate temperatu #3, #4, #5, #6) residir meals observed. The Afternoon observation at 5:20 PM revealed a room table to prepare Continued observation to consist of BBQ pull macaroni salad, juice observations revealed bowl with yams on the coming out of it. Subs revealed all clients to meal. Additional obset to state the yams are reply "then blow it". A observation did staff of items "yams" to the clients. Interview with the faci revealed staff have be items at an appropria- serving to the clients. revealed most of the s	ure for 6 of 6 clients (#1, #2, ng in the facility for 1 of 2 finding is: as in the facility on 5/28/24 all clients to sit at the dining of the dinner meal. Ins revealed the dinner meal ed pork, yams, coleslaw, and water. Further d staff to place the serving e table while steam was sequent observations participate in the dinner rvations revealed client #1 too hot to eat and staff B to t no point during the check or serve the dinner ients at an appropriate lity administrator on 5/29/24 een trained to prepare menu te temperature prior to Continued interview staff are newly hired staff meals are served at the					

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