STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G192	A. BUILDING _____ B. WING _____	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORSYTH GROUP HOME #2	8460 BELEWS CREEK ROAD BELEWS CREEK, NC 27009

(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 159	QIDP CFR(s): 483.430(a) Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- This STANDARD is not met as evidenced by: Based on record reviews and interview, the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure the Person Centered Plan (PCP) for 3 of 3 audit clients (#3, #4, and #6) were sufficiently monitored to determine the need for program revisions and/or modifications regarding expired objectives. The findings are: A. Review on 5/28/24 of client #3's PCP dated 1/17/24 revealed 3 training objectives: 1. By 3/15/23, client #3 will be able to operate a washing machine to do his laundry with 90% verbal assistance for two consecutive review periods (start date 3/15/22). An additional review of the record did not reveal any progress notes regarding the objective. 2. By 11/1/22, client #3 will choose between two activities to work on with 90% accuracy for two consecutive review periods (start date 5/1/21). An additional review of the record did not reveal any progress notes regarding the objective. 3. By 3/10/23, client #3 will identify various clothing with 90% accuracy for two consecutive review periods (start date 3/15/22). An additional review of the record did not reveal any progress notes regarding the objective. Interview on 5/29/24 with the QIDP by phone revealed that the PCP objectives were the most current. QIDP revealed that she had not reviewed	W 159		

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

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or held a team meeting regarding client #3's expired objectives to determine revisions or modification.

B. Review on 5/28/24 of client #4's PCP dated 12/7/23 revealed 2 training objectives:

1. By 11/28/23, client #4 will be able to state his personal information with 100% accuracy for two consecutive review periods (start date 11/28/22). An additional review of the record did not reveal any progress notes regarding the objective.

2. By 11/28/23, client #4 will eat slowly with 90% accuracy for two consecutive review periods (start date 11/28/22). An additional review of the record did not reveal any progress notes regarding the objective.

Interview on 5/29/24 with the QIDP by phone revealed that the PCP objectives were the most current. QIDP revealed that she had not reviewed or held a team meeting regarding client #4's expired objectives to determine revisions or modification.

C. Review on 5/28/24 of client #6's PCP dated 12/7/23 revealed 3 training objectives:

1. By 3/10/23, client #6 will wipe the table after a meal with 90% independence for two consecutive review periods (start date 3/10/22). An additional review of the record did not reveal any progress notes regarding the objective.

2. By 3/10/23, client #6 will be able to operate washing machine to do his laundry with 90% verbal assistance for two consecutive review periods (start date 3/10/22). An additional review

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W 159	Continued From page 2 of the record did not reveal any progress notes regarding the objective. 3. By 5/11/23, client #6 will be able to make change for $1.00 with 95% accuracy for two consecutive review periods (start date 5/11/22). An additional review of the record did not reveal any progress notes regarding the objective. Interview on 5/29/24 with the QIDP by phone revealed that the PCP objectives were the most current. QIDP revealed that she had not reviewed or held a team meeting regarding client #6's expired objectives to determine revisions or modification.	W 159		
W 253	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(2) The facility must document significant events that are related to the client's individual program plan and assessments. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to document a significant event, specifically inappropriate touching/personal space affecting one audit client (#4) to determine if the undocumented behavior requires a tracking tool, an IDT meeting or possible revision to client #4's Behavioral Support Plan (BSP) and Person Centered Plan (PCP). The finding is: During observations at the home on 05/28/24-05/29/24 throughout the survey, client #4 was observed entering two surveyors' personal space and touching both surveyors inappropriately (touching waist, shoulders, chest, and holding arms) 11 separate times. At no point	W 253		

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W 253	Continued From page 3 was staff observed documenting these inappropriate touching/personal space episodes. Record review on 5/29/24 of client #4's PCP dated 12/7/23 and BSP dated 11/15/23 revealed one target behavior of physical aggression (refuse reasonable request by staff). Further review revealed no documentation regarding inappropriate touching/personal space. Interview on 5/29/24 with Staff F revealed client #4 frequently exhibit behaviors of entering personal space and inappropriate touching daily. Further interview with Staff F revealed that client #4"s BSP only states physical aggression as a target behavior and does not include inappropriate touching/personal space. Continued interview with Staff F revealed staff did not document the episodes and were told just to redirect client #4. Interview on 5/29/24 with the facility administrator acknowledged client #4's inappropriate touching/personal space episodes. Further interview with the facility administrator revealed there were no IDT meetings or formal goals regarding inappropriate touching/personal space and that staff should redirect client #4.	W 253		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record review and	W 262		

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interviews, the facility failed to ensure that restrictive techniques and behavior support plans (BSP) were monitored and reviewed annually by the human rights committee (HRC) for 5 of 6 clients (#1, #2, #3, #4 and #5). The findings are:

Observations throughout the recertification survey period from 5/28/24 - 5/29/24 revealed exterior door alarms to chime as staff and surveyors entered and exited the group home.

A. Review of client 1's records on 5/29/24 revealed a signed consent dated 5/10/24 by the legal guardian for exit door alarms. Continued review did not reveal consents for exit door alarms were reviewed or approved by the HRC.

B. Review of client 2's records on 5/29/24 revealed a signed consent dated 3/18/24 by the legal guardian for exit door alarms. Continued review did not reveal consents for exit door alarms were reviewed or approved by the HRC.

C. Review of client 3's records on 5/29/24 revealed a signed consent dated 5/10/24 by the legal guardian for exit door alarms. Continued review did not reveal consents for exit door alarms were reviewed or approved by HRC. Further review revealed a behavior support plan (BSP) dated 3/4/24. Subsequent review of the BSP revealed the use of behavioral medications. Additonal review did not reveal consents were reviewed or approved by the HRC.

D. Review of client 4's records on 5/29/24 revealed a signed consent dated 3/26/24 by the legal guardian for exit door alarms. Continued review did not reveal consents for exit door alarms were reviewed or approved by the HRC.

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W 262	Continued From page 5 E. Review of client 5's records on 5/29/24 revealed a BSP dated 1/1/24 to include the use of psychotic medications. Continued review revealed a signed consent dated 3/4/24 by the legal guardian. Further review did not reveal consents were reviewed or approved by the HRC. Interview with the facility administrator on 5/29/24 revealed that updated signed consent forms could not be located during the survey. Continued interview revealed HRC limitation consent forms for all clients should be updated and signed by the HRC annually.	W 262		
W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure behavior support plans (BSP) were reviewed and approved by the legal guardians for 1 of 6 clients (#3). The finding is: Review of client 3's records on 5/29/24 revealed a behavior support plan (BSP) dated 3/4/24. Further review of the BSP revealed the use of behavioral medications. Further review did not reveal consents were reviewed and approved by legal guardian. Interview with the facility administrator on 5/29/24 revealed that updated signed consent form could not be located during the survey. Continued	W 263		

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W 263	Continued From page 6 interview revealed HRC limitation consent forms for all clients should be updated and signed by the legal guardian annually.	W 263		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on review and interview, the facility failed to ensure fire evacuation drills were conducted at least quarterly for each shift. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The findings are: Review on 5/28/24 of the facility's fire drills from May 2023-April 2024 revealed there were no fire drills documented: 2nd Quarter- June 2023 3rd shift 3rd Quarter- July 2023 1st shift and August 2023 2nd shift During an interview on 5/29/24, with the Qualified Intellectual Disabilities Professional (QIDP) confirmed there were no documented fire drills for the months of June, July, and August of 2023.	W 440		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure staff and clients used proper hand washing and to ensure a sanitary environment to prevent cross contamination. This had the potential to affect all clients (#1, #2, #3,	W 454		

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W 454	Continued From page 7 #4, #5 and #6) in the home. The findings are: A. Observations on 5/28/24 during the dinner mealtime revealed client #3 and client #4 were prompted by staff to set the two dining tables. Continued observations revealed client #3 was prompted by staff to place the cups and napkins on the dining tables. Further observations revealed staff did not prompt clients to clean the dining tables first. Subsequent observations revealed client #4 touched the bottom of his sock several times in between setting the plates and utensils on the dining tables. At no point did staff prompted client #4 to wash his hands prior to touching the plates and the utensils. Interview on 5/29/24 with the facility administrator revealed client #3 and client #4 should have been prompted to clean the tables and wash their hands prior to and in between mealtimes. B. Observations on 5/29/24 during the breakfast mealtime revealed staff prompted client #2 to set the dining tables. Continued observations revealed staff did not prompt client #2 to wipe the tables prior to him placing down the cups and utensils. Further observations revealed client #2 sat at the dining table and sneezed three times over the table settings. Subsequent observations revealed staff asked client #2 to rewash his hands but at no point did staff remove the table settings from the table after client #2 sneezed. Interview on 5/29/24 with the facilty administrator revealed staff should have prompted client #2 to wipe down and reset the table after sneezing.	W 454		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii)	W 473		

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W 473	Continued From page 8 Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure food was served at an appropriate temperature for 6 of 6 clients (#1, #2, #3, #4, #5, #6) residing in the facility for 1 of 2 meals observed. The finding is: Afternoon observations in the facility on 5/28/24 at 5:20 PM revealed all clients to sit at the dining room table to prepare for the dinner meal. Continued observations revealed the dinner meal to consist of BBQ pulled pork, yams, coleslaw, macaroni salad, juice and water. Further observations revealed staff to place the serving bowl with yams on the table while steam was coming out of it. Subsequent observations revealed all clients to participate in the dinner meal. Additional observations revealed client #1 to state the yams are too hot to eat and staff B to reply "then blow it". At no point during the observation did staff check or serve the dinner items "yams" to the clients at an appropriate temperature. Interview with the facility administrator on 5/29/24 revealed staff have been trained to prepare menu items at an appropriate temperature prior to serving to the clients. Continued interview revealed most of the staff are newly hired staff and should ensure all meals are served at the appropriate temperatures.	W 473		