STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G114	A. BUILDING _____ B. WING _____	C 07/18/2024

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 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 conducted on 7/18/24 for intakes #NC00218761 and #NC00219202. The complaint was substantitated with no deficiencies cited. However, one deficiency related to the complaint was cited.	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on document reviews and interviews, the facility failed to ensure all allegations were thoroughly investigated, including injuries of unknown source. This affected 2 of 3 audit clients (#1 and #2). The findings are: A. Review on 7/18/24 of a facility investigation revealed on 5/30/24 the Program Manager (PM) received a call from the Site Supervisor (SS) indicating he had received a report alleging that on 5/25/24 while at an event hosted by Direct Support Professional (DSP) Staff G from the group home, two DSP (Staff A and Staff B) "were not performing their duties and smoking marijuana." The investigation noted the event was attended by four DSP (Staff A, Staff B, Staff C and Staff D) who were working and on the clock that day and and four clients (#1, #2, #3 and #5) from the home. Two other DSP (Staff E and Staff F) who were not working and off the clock also attended the event. The report noted Staff A and Staff B were suspended pending the investigation for neglect. Additional review of written statements from the investigation revealed Staff G had reported to the	W 154		

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

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W 154	Continued From page 1 SS that her family member had called her to let her know that while at the event he had smelled marijuana on one of the DSP staff who worked at the group home. The report indicated Staff E also noted, "...I was told by [Staff G's] family that they were getting high when they were supposed to be helping with the consumers." Review of statements from the investigation did not include a statement from Staff G's family member. In addition, statements from the four staff working at the event did not indicate any information regarding their knowledge of a DSP smoking marijuana at the event. Further review of the investigation revealed the following regarding Staff C and her interactions with client #2: * Client #2 was "very upset and angry at [Staff C] because she kept on taunting him and raising her voice by saying that if he did not behave, she would take him back to the house. His behavior ended up being very bad and I kept having to make sure he was okay." * "[Client #2] expressed that my other coworker [Staff C] was being very mean to him and giving him dirty looks. He also expressed that he doesn't like when she is at the home because she always raises her voice at him and talks to him like a child. As he was expressing himself, I saw that it was starting to make him angry since his face was turning red..." Continued review of investigation did not reveal any additional information regarding Staff C and her inappropriate interactions with client #2 or the facility's response to the statements.	W 154		

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W 154	Continued From page 2 During an interview on 7/18/24, the PM indicated she could not be sure if the staff interviewed were asked any direct questions regarding the inappropriate and illegal use of marijuana while at the event and on duty. The PM indicated the facility has policies against the use of illegal drugs while on duty. The PM also acknowledged Staff G's family member should have been interviewed as well. Additional interview also revealed the facility had not addressed the statements regarding allegations that Staff C had inappropriate interactions with client #2. The PM confirmed the allegations against Staff C discovered during the course of the investigation should have been investigated. B. Review on 7/18/24 of a facility investigation dated 6/20/24 revealed on 6/19/24 the PM received a call from the SS at approximately 12:15pm. He indicated that "when he returned to the home...he noticed that while [Client #1] was sitting in the living room he noticed that he had a black eye (right) and right hand was swollen." Additional review of the investigation indicated Staff D, Staff G and Staff H were interviewed regarding the injuries and their interviews yielded conflicting statements. For example, Staff H indicated client #1 had been elbowed in the face by client #2 while riding on the van. However, Staff D and the SS were also on the van at the time and they indicated they did not hear or see anything and could not corroborate Staff H's account. Further review of investigation indicated the SS felt "something happened" between the time Staff H was with client #1 in his bedroom and the time he took the client for a walk. The report concluded, "Based upon the statements from	W 154		

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W 154	Continued From page 3 interviews and reviewed documents, this writer has determined this investigation has been determined inconclusive." The investigation also noted two staff statements which indicated Staff D "grabbed" client #1's left hand to keep him from reaching for food at the breakfast meal that morning. The report revealed at that time Staff G "told [Staff D] that she shouldn't have grabbed his hand like that." Although it was determined that she grabbed client #1's left hand (not the injured hand), the report did not indicate an inquiry was made into Staff D's inappropriate interaction with client #1. Interview on 7/18/24 with the Program Coordinator (PC) who conducted the investigation and the PM confirmed no inquiry was conducted regarding Staff D's inappropriate contact with client #1 at the breakfast meal. The PM confirmed any new allegations discovered during the course of an investigation should also be investigated. The PM and PC acknowledged although abuse was not substantiated, staff working with client #1 failed to adequately monitor and supervise the client in order to prevent the subsequent injuries. Further interview with the PM indicated additional training was needed for management staff on conducting thorough investigations.	W 154		