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 _____	03/05/2025

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 342	NURSING SERVICES CFR(s): 483.460(c)(5)(iii) 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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients. This STANDARD is not met as evidenced by: Based on observations, record review and interview, nursing failed to ensure all medication aides were trained to only dispense medications with attached labels that were legible; with the client identified and dosage and instructions for administering. This affected 1 of 4 audit clients (#6). The finding is: During morning observations on 3/5/25 at 6:20am, the home manager removed a bottle of Liquid Chlorophyll and Vitamin D3 125mg from the medication cart with faded, oily labels and prepared to give it to client #6, who resisted taking them. The home manager retrieved a box of the Liquid Chlorophyll from the medication cart, but it was an over the counter purchase and did not have client #6 name or dosage instructions on it. Record review on 3/5/25 of the February 2025 Physician's Order for client #6 revealed an order for Vitamin D3 5000 unit. He should take 1 ml by mouth every morning and it should be refrigerated after opening. In addition there were instructions that read, "Literal order, MAR (medication administration record) only (Other Vendor), Chlorophyll liquid drops: take 2 ml by mouth every morning for halitosis.	W 342		

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

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	34G336	A. BUILDING _____ B. WING _____	03/05/2025

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W 342	Continued From page 1 Interview on 3/5/25 with the home manager revealed he knew the purpose of the medications for client #6 but acknowledged there was no legible label with name or instructions. Interview on 3/5/25 with the nurse revealed the medication was ordered online, hence the reason for no label on packaging. The nurse also acknowledged she dropped off a brand new box of Vitamin D3 with the label affixed last week and staff should have retained it.	W 342		
W 369	DRUG ADMINISTRATION CFR(s): 483.460(k)(2) The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to administer medication for 1 of 4 audit clients (#3) without error. The finding is: During observation on 3/5/25 at 6:34am, the home manager was administering medications to client #3. The home manager dispensed 2 pills of Chlorpromaz 10mg, 1 pill of Clonidine 0.1mg, 1 pill of Sertraline 100mg and 2 capsules of Dexmethylphe 20mg ER. On 3/5/25, a review of February 2025 Physician's Orders for client #3 revealed he should have received 2 pills of Clonidine 0.1mg. Interview on 3/5/25 with the home manager revealed he noticed the blister pack of Clonidine 0.1mg only had 1 of 2 pills in the slot that he	W 369		

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	34G336	A. BUILDING _____ B. WING _____	03/05/2025

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 369	Continued From page 2 punched out. The home manager decided to give client #3 only one of the pills and acknowledged he had not notified the nurse. Interview on 3/5/25 with the nurse revealed if there is a problem with the medication, staff should contact her and she can authorize to take an available pill left in the back to ensure the full dose is received. The nurse acknowledged she was not informed of the incident with client #3's Clonidine this morning.	W 369		
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 record review and interview, the facility failed to ensure that fire drills were conducted every quarter for each shift. The finding is: Record review on 3/5/25 of all fire drills conducted in the home since 4/17/24 revealed there were no first shift drills between April-June, 2024 (2nd quarter) and July-September 2024 (3rd quarter). Interview on 3/5/25 with the Qualified Intellectual Disabilities Professional (QIDP) led to an acknowledgement that some of the fire drills were missed last year.	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:	W 454		

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W 454	Continued From page 3 Based on observations, record review and interviews, the facility failed to ensure that food was not retained after contamination. This affected 2 of 4 audit clients (#2 and #6). The finding is: During observations in the home on 3/4/25 at 5:05pm, Staff B placed an opened jar of applesauce on the medication cart with client #6 standing by. Client #6 was very active, reaching for items on top of the cart and at one point, client #6 took his finger and rubbed inside the lid of the applesauce in front of Staff B and the nurse. Staff B removed applesauce and placed in a medicine cup with his medication, for him to ingest. Staff B kept the applesauce and used it to mix medicine for client #2 at 5:10pm. Interview on 3/5/25 with the nurse revealed the applesauce should be kept in separate pre-filled containers to secure them and discard once they are touched.	W 454		