STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G133	A. BUILDING _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOREST BEND GROUP HOME	47 S OAK STREET BREVARD, NC 28712

(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
E 015	Subsistence Needs for Staff and Patients CFR(s): 483.475(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (iii) The provision of subsistence needs for	E 015		

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

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E 015	Continued From page 1 hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure emergency provisions were met relative to the emergency water supply. The findings is: Observation on 9/10/25 of the facility's emergency supplies revealed no emergency water. Interview on 9/10/25 with the Residential Team Leader (RTL) confirmed that the facility has no current emergency supply of water.	E 015		
E 036	EP Training and Testing CFR(s): 483.475(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54,	E 036		

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E 036	Continued From page 2 Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and	E 036		

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E 036	Continued From page 3 testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to conduct annual inservice training of the facility's emergency preparedness plan (EPP). The finding is: Review on 9/10/25 of the facility's EPP revealed no evidence of an inservice training on the facility's EPP. Interview on 9/10/25 with the Residential Team Leader (RTL) confirmed that the facility has no evidence of conducting an inservice training on their emergency preparedness Manuel.	E 036		
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. This STANDARD is not met as evidenced by:	W 130		

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W 130	Continued From page 4 Based on observation, record review and interview, the facility failed to ensure that privacy was maintained for 1 of 3 audit clients (#3). The finding is: During observations in the home on 9/10/25 from 6:45 AM to 7:30 AM, client #3 was observed in his bedroom nude and in an incontinence product. Staff B was observed to respond to client #3 before he could leave his room nude when he opened the door. Further observation revealed client #1 to walk over to ask a question of Staff B and see client #3 exposed. Subsequent observation revealed client #2 to sit in a chair outside of client #3 door the entire time it was open. Review on 9/10/2025 of client #'3s person-centered plan (PCP) dated 2/5/25 revealed client #3 has a treatment objective to ensure the privacy of others. Interview on 9/10/25 with the qualified intellectual disabilities professional (QIDP) confirmed Staff B should have closed client #3's bedroom door to ensure his privacy.	W 130		
W 186	DIRECT CARE STAFF CFR(s): 483.430(d)(1-2) The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observations, record review and	W 186		

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W 186	Continued From page 5	W 186		

interviews, the facility failed to provide sufficient direct care staff to manage and supervise clients for 1 of 3 audited clients (#3). The finding is:

Observation in the group home on 9/10/25 at 6:45 AM revealed one Staff B to be present with three clients. Continued observations revealed client #1 in his bedroom with the door closed, client #2 sitting in a chair outside of client #3's bedroom, and client #3 awake and disrobed in his bedroom. Further observations from 6:45 AM to 7:28 AM revealed Staff B to stand outside of client #3's bedroom and continuously redirect him to wait for their shower. Additional observation from 6:45 AM to 7:28 AM revealed client #2 to remain seated in the chair outside of client #3's bedroom. Subsequent observation at 7:28 AM revealed the Residential Team Leader (RTL) to arrive and support client #3 with their shower.

Interview with Staff B at the group home on 9/10/25 revealed first shift staff are scheduled for 7:00 AM. Continued interview with Staff B revealed client #3 was requesting his shower, but they were redirecting him to wait due to having to supervise client #2.

Review of client #2's record on 9/10/25 revealed a person-center plan (PCP) dated 6/11/25. Review of the PCP indicated no supervision guidelines for client #2.

Interview with the RTL and qualified intellectual disabilities professional (QIDP) on 9/10/25 confirmed client #2 does not have supervision guidelines. Continued interview with the RTL and QIDP revealed Staff B should have supported client #3 with their shower as requested.

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W 249	Continued From page 6	W 249		
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 3 of 3 audited clients (#1, #2, and #3) received a continuous active treatment program consisting of needed interventions as identified in their person-centered plans (PCPs). The findings are: A. The facility failed to provide formal or informal active treatment opportunities for clients #1, #2, and #3. For example: Observation in the group home on 9/9/25 at 4:00 PM revealed Staff A, Staff B, and the Residential Team Leader (RTL) to be present with clients #1, #2, and #3. Observation of client #1 from 4:00 PM to 5:45 PM revealed him to remain idle in his room until being prompted to make his drink for the dinner meal at 5:45 PM. Observation of client #2 from 4:00 PM to 5:18 PM revealed her to remain idle in the common area until being offered a coloring activity at 5:18 PM. Continued observation of client #2 revealed her to continue the coloring activity until the dinner meal at 5:45. Observation of client #3 from 4:00 PM to 4:55 PM	W 249		

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W 249	Continued From page 7	W 249		

revealed him to remain idle in the common area until being prompted to assist with meal preparation at 4:55 PM. Continued observations of client #3 from 5:05 PM to 5:45 PM revealed him to remain idle at the dining table until the dinner meal at 5:45 PM.

Observations of Staff A, Staff B and the RTL from 4:00 PM to 5:45 PM revealed them to engage in various tasks including preparing the dinner meal, sorting/inventorying the emergency food supply, office work, laundry, setting the dinner table, and serving the dinner meal. Further observation at 5:45 PM revealed Staff A to support client #3 with his dinner meal and client #1 and #2 to eat independently.

Review of client #2's record on 9/10/25 revealed a PCP dated 6/11/25 which indicated treatment goals for completing the process of sweeping with 85% accuracy and setting the dinner table place settings with verbal assistance with 90% accuracy.

Interview with the RTL and qualified intellectual disabilities professional (QIDP) on 9/10/25 revealed active treatment should be provided on-going throughout the day. Continued interview with the RTL and QIDP confirmed staff are responsible from engaging clients in active treatment at all opportunities and should not be completing menial tasks while the clients remain idle.

B. The facility failed to ensure client #2 had access to her eyeglasses. For example:

Observations in the group home throughout survey 9/9/25 - 9/10/25 revealed client #2 to

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W 249	Continued From page 8 participate in a variety of activies to include; coloring activity, the dinner meal, medication administration, setting her breakfast place settings, pouring beverages and the breakfast meal. At no point during observations did staff prompt or provide client #2 with her eyeglasses that were in her room on her window seal. Review of records on 9/10/2025 for client #2 revealed a PCP dated 6/11/25. Further review of the PCP revealed an objective to tolerate glasses. Continued review of the PCP revealed a 9/20/24 Carolina Ophthalmology appointment with a recent diagnosis of Mild Cataracts and a new glasses prescription. Interview with the RTL on 9/10/25 revealed client #2 should wear her glass at all times. Further interview with the RTL and QIDP revealed staff report that client #2 "threw her glasses somewhere and they are currently missing".	W 249		