PRINTED: 08/16/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
		34G337	B. WING			08,	/14/2018
NAME OF PROVIDER OR SUPPLIER KING GEORGE GROUP HOME			•	STREET ADDRESS, CITY, STATE, ZIP CODE 323 KING GEORGE ROAD GREENVILLE, NC 27834			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	Primary/Alternate M CFR(s): 483.475(c)(c) [(c) The [facility] mu emergency prepare that complies with F and must be review annually.] The comrall of the following: (3) Primary and alte communicating with (i) [Facility] staff. (ii) Federal, State, tremergency manage *[For ICF/IIDs at §44 alternate means for ICF/IID's staff, Fedelocal emergency mathis STANDARD is Based on documer facility failed to devecommunicating with local governments of finding is:	leans for Communication (3) st develop and maintain an dness communication plan rederal, State and local laws ed and updated at least munication plan must include rnate means for the following: ribal, regional, and local ment agencies. 83.475(c):] (3) Primary and communicating with the eral, State, tribal, regional, and anagement agencies. In not met as evidenced by: Intation and interviews, the elop an alternate means for facility staff, regional and during an emergency. The		032		AIE	
	preparedness (EP)	of the facility's emergency did not include any ng alternate means of					
ADODATORY	revealed if the land were down they did communicate during	on 8/14/18, management line phone and cell service have any additional way to g an emergency.			TITLE		(X6) DATE

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

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.

Facility ID: 956230

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING		
		34G337	B. WING		08/14/2	018
NAME OF PROVIDER OR SUPPLIER KING GEORGE GROUP HOME			323	REET ADDRESS, CITY, STATE, ZIP CODE 3 KING GEORGE ROAD REENVILLE, NC 27834	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COR	(X5) MPLETION DATE
E 037	ASCs, PACE organizand dialysis facilities (i) Initial training in erpolicies and procedustaff, individuals provarrangement, and voexpected role. (ii) Provide emergencleast annually. (iii) Maintain docume (iv) Demonstrate starprocedures. *[For Hospitals at §4: at §491.12:] (1) Trainor RHC/FQHC] must (i) Initial training in erpolicies and procedustaff, individuals provarrangement, and voexpected roles. (ii) Provide emergencleast annually. (iii) Maintain docume (iv) Demonstrate starprocedures. *[For Hospices at §4 hospice must do all of (i) Initial training in erpolicies and proceduhospice employees, services under arranexpected roles.	The [facility, except CAHs, rations, PRTFs, Hospices, I must do all of the following: mergency preparedness res to all new and existing viding services under slunteers, consistent with their crypreparedness training at sentation of the training. If knowledge of emergency 82.15(d) and RHCs/FQHCs sing program. The [Hospital do all of the following: mergency preparedness res to all new and existing viding on-site services under slunteers, consistent with their crypreparedness training at sentation of the training. If knowledge of emergency 18.113(d):] (1) Training. The	E 037			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		34G337	B. WING		08/14/2018	
	ROVIDER OR SUPPLIER DRGE GROUP HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 323 KING GEORGE ROAD GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
E 037	least annually. (iv) Periodically revie emergency prepared employees (includin special emphasis pla procedures necessared others. *[For PRTFs at §44' program. The PRTF (i) Initial training in expolicies and procedustaff, individuals programent, and versected roles. (ii) After initial training preparedness training preparedness training (iii) Demonstrate state procedures. (iv) Maintain docume preparedness training in expected roles (ii) Initial training in expected roles. (iv) Maintain docume preparedness and procedures and procedus at fi, individuals programgement, contravolunteers, consiste (ii) Provide emergentleast annually. (iii) Demonstrate state procedures, including what to do, where to case of an emergentless and procedures.	ew and rehearse its dness plan with hospice g nonemployee staff), with acced on carrying out the ary to protect patients and and the following: mergency preparedness ures to all new and existing viding services under colunteers, consistent with their ag, provide emergency g at least annually. If knowledge of emergency entation of all emergency entation of all emergency all of the following: mergency preparedness ures to all new and existing viding services under colunteers, consistent with their ag, provide emergency entation of all emergency entation of all emergency entation of all emergency all of the following: mergency preparedness ures to all new and existing viding on-site services under actors, participants, and ant with their expected roles. The following entation of the following at t	E 03	7		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		34G337	B. WING			08/	14/2018
NAME OF PROVIDER OR SUPPLIER KING GEORGE GROUP HOME				32	TREET ADDRESS, CITY, STATE, ZIP CODE 23 KING GEORGE ROAD BREENVILLE, NC 27834		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 037	CORF must do all of (i) Provide initial train preparedness policie and existing staff, inc under arrangement, a with their expected ro (ii) Provide emergence least annually. (iii) Maintain docume (iv) Demonstrate staff procedures. All new p and assigned specific the CORF's emerger their first workday. Th include instruction in alarm systems and s equipment. *[For CAHs at §485.6 The CAH must do all (i) Initial training in er policies and procedu reporting and extinguand where necessary personnel, and guest cooperation with firef authorities, to all new individuals providing and volunteers, cons roles. (ii) Provide emergence least annually. (iii) Maintain docume (iv) Demonstrate staff procedures.	the following: ing in emergency s and procedures to all new dividuals providing services and volunteers, consistent bles. by preparedness training at intation of the training. If knowledge of emergency bersonnel must be oriented bersponsibilities regarding bersonnel within 2 weeks of the training program must the location and use of dignals and firefighting 625(d):] (1) Training program. of the following: mergency preparedness res, including prompt dishing of fires, protection, of, evacuation of patients, is, fire prevention, and dighting and disaster	E	037			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G337	B. WING		08/14/2018		
	ROVIDER OR SUPPLIER DRGE GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 323 KING GEORGE ROAD GREENVILLE, NC 27834				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION		
E 037	preparedness polici and existing staff, in under arrangement, with their expected documentation of the demonstrate staff know procedures. Thereat emergency prepare annually. This STANDARD is Based on interview failed to assure direct trained on the faciliting finding is: Staff had not receive emergency plan (EFReview on 8/13/18 of training inservice show prepared to the faciliting for EP after review. Staff interviews (2) of following; staff were procedures regarding evinformation and whe concerning information and whe	e initial training in emergency es and procedures to all new idividuals providing services and volunteers, consistent roles, and maintain e training. The CMHC must nowledge of emergency fter, the CMHC must provide dness training at least and record review, the facility ct care staff were sufficiently y's emergency plan (EP). The ed adequate training on the ed adequate training on the for facility documents revealed eets for direct care staff in disaster and EP training in ere were no additional November 2017 available for	E 037				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G337	B. WING		08/14/2018		
NAME OF PROVIDER OR SUPPLIER KING GEORGE GROUP HOME			:	STREET ADDRESS, CITY, STATE, ZIP CODE 323 KING GEORGE ROAD GREENVILLE, NC 27834	ODE:		
(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 SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION		
E 037	Continued From page	e 5	E 037	7			
W 210	EP after November 2 INDIVIDUAL PROGR CFR(s): 483.440(c)(3	AM PLAN	W 210				
	assessments or reas	admission, the must perform accurate sessments as needed to ninary evaluation conducted					
	Based on record rev failed to ensure the ir performed accurate a after admission. This	not met as evidenced by: iew and interview the facility iterdisciplinary team assessments within 30 days affected 2 of 2 newly (#3 and #6). The findings					
	Client #3 did not re therapy (OT) or a sp timely manner.	eceive a occupational eech (SP) assessment in a					
	she was admitted into Further review of clie OT assessment date revealed a SP assess	client #3's record revealed to the facility on 9/11/17. Int #3's record revealed an d 11/20/17. Further review sment dated 11/1/17. No assessments were available					
	intellectual disabilities informed the surveyo	r, the OT and SP only assessment for the was aware it was not					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		34G337	B. WING		0	8/14/2018
NAME OF PROVIDER OR SUPPLIER KING GEORGE GROUP HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 323 KING GEORGE ROAD GREENVILLE, NC 27834		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		OULD BE	(X5) COMPLETION DATE
W 210	therapy (OT) or a sprtimely manner. Review on 8/14/18 of she was admitted in Further review of clic OT assessment date revealed a SP assess additional OT or SP in the record. During an interview of intellectual disabilities informed the survey assessment were the	eceive a occupational peech (SP) assessment in a of client #6's record revealed to the facility on 9/5/17. For the the facility on 9/5/17. Further review esment dated 11/3/17. No assessments were available on 8/14/18, the qualified es professional (QIDP) for, the OT and SP eonly assessment for the was aware it was not	W 21			