STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G337	A. BUILDING _____ B. WING _____	08/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING GEORGE GROUP HOME	323 KING GEORGE ROAD GREENVILLE, NC 27834

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E 032	Primary/Alternate Means for Communication CFR(s): 483.475(c)(3) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (3) Primary and alternate means for communicating with the following: (i) [Facility] staff. (ii) Federal, State, tribal, regional, and local emergency management agencies. *[For ICF/IIDs at §483.475(c):] (3) Primary and alternate means for communicating with the ICF/IID's staff, Federal, State, tribal, regional, and local emergency management agencies. This STANDARD is not met as evidenced by: Based on documentation and interviews, the facility failed to develop an alternate means for communicating with facility staff, regional and local governments during an emergency. The finding is: The facility failed to develop an alternate means for communicating with staff, regional and local governments during an emergency. Review on 8/13/18, of the facility's emergency preparedness (EP) did not include any information regarding alternate means of communication. During an interview on 8/14/18, management revealed if the land line phone and cell service were down they did have any additional way to communicate during an emergency.	E 032	Preperation and excution of this plan of correction does not constitute admission or agreement by the provider or the truth of fact alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or exicuted solely because it is required by the provision of federal and state law. E032 King George will use a cell phone with portable phone charger to be used as an alternative means of communication during emergency situations. The use of poster boards, markers and tape will also be used to make signs to post in windows as needed. Plan to prevent re-occurance: Monitoring will be conducted monthly by the PD during environmental assessments. Lic. & Cert. Section SEP 10 2018 DHSR - Mental Health DHSR - Mental Health SEP 10 2018 Lic. & Cert. Section	9/30/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia B. Stevens, TITLE: Program Director, (X6) DATE: 8/17/18

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.

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E 037	EP Training Program CFR(s): 483.475(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures.	E 037	E037 GHM will inservice all new employees on the emergency preparedness policies and procedures upon hire and on-oning training will be conducted during monthly staff meetings to endure staff fully understand policies and procedures as it relates to emergency preparedness. Plan to prevent re-occurrance: Monitoring will be conducted monthly by the PD to ensure compliance.	9/30/2018

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E 037	Continued From page 2 (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training.	E 037		

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E 037	Continued From page 3 *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The	E 037		

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E 037	Continued From page 4 CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure direct care staff were sufficiently trained on the facility's emergency plan (EP). The finding is: Staff had not received adequate training on the emergency plan (EP). Review on 8/13/18 of facility documents revealed training inservice sheets for direct care staff in regards to fire drills, disaster and EP training in November 2017. There were no additional training for EP after November 2017 available for review. Staff interviews (2) on 8/14/18, revealed the following; staff were able to provide the procedures regarding fire drills and disaster drills; however, the staff could not provide specific details regarding evacuation sites, contact information and where they could find the concerning information the facility's EP program. Interview on 8/14/18, with the qualified intellectual disabilities professional (QIDP) and management revealed they have not provided any additional training for direct care staff specific to the facility's	E 037		

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E 037	Continued From page 5 EP after November 2017.	E 037		
W 210	INDIVIDUAL PROGRAM PLAN CFR(s): 483.440(c)(3) Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure the interdisciplinary team performed accurate assessments within 30 days after admission. This affected 2 of 2 newly admitted audit clients (#3 and #6). The findings are: 1. Client #3 did not receive a occupational therapy (OT) or a speech (SP) assessment in a timely manner. Review on 8/14/18 of client #3's record revealed she was admitted into the facility on 9/11/17. Further review of client #3's record revealed an OT assessment dated 11/20/17. Further review revealed a SP assessment dated 11/1/17. No additional OT or SP assessments were available in the record. During an interview on 8/14/18, the qualified intellectual disabilities professional (QIDP) informed the surveyor, the OT and SP assessment were the only assessment for the client. However she was aware it was not completed in a timely matter.	W 210	W210 QP will continue to work with all disciplines and provide them with advance notice and deadlines for completing initial evaluations in a timely manner as required within the first thirty days of admission. QP will follow up with disciplines two weeks prior to the thirty day deadline to provide a courtesy reminder of the set deadline. QP will utilize Admissions Checklist to ensure that all initial evaluations are submitted in a timely manner within the thirty day window. Plan to prevent re-occurrance: PD will review Admissions Checklist for all new admissions prior to the thirty day meeting to ensure compliance.	9/30/2018

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W 210	Continued From page 6 2. Client #6 did not receive a occupational therapy (OT) or a speech (SP) assessment in a timely manner. Review on 8/14/18 of client #6's record revealed she was admitted into the facility on 9/5/17. Further review of client #6's record revealed an OT assessment dated 11/20/17. Further review revealed a SP assessment dated 11/3/17. No additional OT or SP assessments were available in the record. During an interview on 8/14/18, the qualified intellectual disabilities professional (QIDP) informed the surveyor, the OT and SP assessment were the only assessment for the client. However she was aware it was not completed in a timely matter.	W 210		