DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G061	B. WING			R 08/19/2019	
NAME OF I	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	00/	13/2013
					77 MISS GEORGIA COURT		
GEORGI	A COURT				ARY, NC 27511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS		W 000				
{W 255}	previous deficiencie deficiencies were re noncompliance was out of compliance.	ucted on 8/19/19 for all es cited on 6/11/19. Two of the ecited and no new area of s found. The facility remains FORING & CHANGE (1)(i)	{W 2	55}			
	least by the qualified professional and result to since successfully complicated in the ind this STANDARD is Based on record refailed to ensure clied Plan (IPP) was revised audit clients. The fix Client #6's IPP was	s not revised after he had					
	3/27/19 revealed at episodes of non-coper month for one y 3/9/17. Additional the objective from revealed client #6 h noncompliance/fail over the past 30 mc Interview on 8/19/1	of client #6's IPP dated n objective to exhibit 0 impliance/failure to cooperate year. The objective was dated review of progress notes for June '17 - February '19 nad exhibited 0 ure to cooperate behaviors					
		had been met; however, he					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE					TITLE		(X6) DATE

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		34G061	B. WING				⋜ 19/2019
NAME OF PROVIDER OR SUPPLIER GEORGIA COURT				1	OT MISS GEORGIA COURT CARY, NC 27511	<u> 00/</u>	13/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
{W 255}	has not received a new behavior plan from the psychologist.		{W 255}				
{W 263}	CFR(s): 483.440(f)(The committee sho are conducted only	uld insure that these programs with the written informed t, parents (if the client is a	{W 20	63}			
	Based on record refailed to ensure a re Program (BSP) was written informed co	s not met as evidenced by: eview and interview, the facility estrictive Behavior Support s only conducted with the nsent of a legal guardian. audit clients (#6). The finding					
	informed consent fr Review on 8/19/19 a BSP dated 3/9/17 physical aggression cooperate. Addition identified the use of Melatonin. Further the guardian had sign The consent also in this authorization w	not include a current written from his legal guardian. of client #6's record revealed in the BSP addressed in and noncompliance/failure to hal review of the BSP if Ability, Paxil, Ativan and review of the record revealed gned a consent dated 3/9/18. Indicated, "I understand that it ill expire on 3/8/19 and will not be the date of reversional."					
	authorization. The r written informed co Interview on 8/19/19 Disabilities Professi	om the date of my original record did not include a current insent signed by the guardian. 9 with the Qualified Intellectual ional (QIDP) confirmed client expired and no current written					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		34G061	B. WING _			R / 19/2019	
NAME OF PROVIDER OR SUPPLIER GEORGIA COURT				STREET ADDRESS, CITY, STATE, ZIP CODE 107 MISS GEORGIA COURT CARY, NC 27511		13/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
{W 263}	Continued From pa informed consent h		{W 26	3}			