PRINTED: 08/28/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	PLE CONSTRUCTION  3		(X3) DATE SURVEY COMPLETED	
		34G265	B. WING			C / <b>23/2019</b>	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 498 & 500 SEAN DRIVE GREENVILLE, 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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS	3	W 00	00			
W 122	Intakes: NC0015494: NC00154958, NC00- cited. It was determin Protections was out of CLIENT PROTECTION CFR(s): 483.420	154684. Deficiencies were ned the COP of Client of compliance. DNS ure that specific client	W 12	22			
W 153	This CONDITION is not met as evidenced by: The facility failed to ensure that all allegations of neglect and abuse were reported immediately to the administrator and to other officials in accordance with state law (W153); and failed to provide evidence that all alleged violations were thoroughly investigated (W154).  The cumulative effect of these systemic practices resulted in the facility's failure to provide statutorily mandated client protections.  STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(2)  The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.		W 18	53			
	Based on review of i	not met as evidenced by: investigations, client records					
ABORATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE		(X6) DATE	

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		34G265	B. WING			C 8/23/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 498 & 500 SEAN DRIVE GREENVILLE, NC 27834	<u> </u>	0/23/2013
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W 153	allegations of abusing Personnel Registry administrator within General Statute 13 Article 15. This affethe facility (#6, #7, include:  A. Allegations of mit to the Administrator to the Administrator Review on 8/22/19 Facility Nurse A to dated 8/8/19 allege 8/7/19 the Mickey but #7's gastrostomy. Not insert the Mickey but to insert the Mickey the Nurse's hand a took the button bact gastrostomy. Nurse poked around in clito jab the Mickey bushoved the sharp ethics statement was and dated 8/8/19.  Interview on 8/22/11	facility failed to report all e or neglect to Health Care (HCPR) and to the 24-Hours as required by N.C. 1E-256, which is under 131E ected 5 of 5 sampled clients at #20, #24, #29). The findings  istreatment were not reported or HCPR regarding client #7.  of written allegations from the Director of Nursing (DON) d during client #7's bath on button was pulled out of client When the Facility Nurse A tried or Button, staff A took it out of and said, "I'll do it." Nurse A ek and got it reinserted into the extend Also alleged that staff A eent #7's gastrostomy trying to button in. She also alleged she and of a Q-Tip in the button. Extend signed by Facility Nurse A  9 with Facility Nurse A pproached the Director of	W 15	53		
	Nursing with conce with her replacing a She stated she gav 8/8/19 of these alle Nursing.  Interview on 8/22/1 been assisting with when his Mickey Br	rns about staff A interfering a Mickey Button for client #7. re a written statement on gations to the Director of  9 with staff A revealed she had client #7's bath on 8/7/19 utton came out of gastrostomy. stacted Facility Nurse A to				

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CTION SHOULD BE THE APPROPRIATE		(X5) COMPLETION DATE
W 153	into the Gastrostomy. revealed facility nurses was having difficulty. watched the Nurses of Mickey button for clie tried to assist the Nurbutton away from her very upset but Nurse Mickey Button. Staff A What did she [The Nurbutton would she tell on mether?" When asked if the her about these allegal Interview on 8/22/19 revealed she had recollent #7 on 8/8/19 in being pulled out and of Mickey Button and pogastrostomy. The DO had not been investighad told the administrate she stated the administrate she shall be she shall be she shall be she shall be	Additional interview Additional interview A tried more than once and Staff A stated she had several times reinsert the int #7. She stated that she se and took the Mickey She stated Nurse A was A was able to replace the A then asked the surveyor," irse] tell you that I did? Why when I was trying to help the DON had interviewed ations, she stated, "No."  with the Director of Nursing eived allegations involving volving his Mickey Button staff A trying to reinsert his beking a Q-Tip into client #7's N stated these allegations ated. When asked if she rator about the allegations, strator was away from work she did not contact her. confirmed these allegations d to Health Care Personnel ated she had held onto asked facility Nurse A to talk with her on 8/12 and dity Nurse A did not come to interview confirmed these d 8/8/19 the day after the the DON confirmed these	W 1	153			

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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
W 153	2018) on reporting a revealed, "The agen notification of the He Registry, pursuant to 131-E-255-256. The will submit a 24 hour Department of Facili Personnel Registry allegation has been Additional review of "The Administrator/E investigation within a abuse, neglect, expl unknown origin. The the staff member alleact of abuse should for the duration of the supervision is needed take necessary action people involved."  Review of facility po "Neglect is generally provide services and protect a person from psychological harm. harm is defined as a omission, accident of substantiated allegal was harm to the perharm."  Interview via phone of Operations for the allegations involving on 8/7/19 were not resulted to the substantial of the allegations involving on 8/7/19 were not resulted.	Ilegations of mistreatment cy will ensure proper ealth Care Personnel to to state requirement G.S. administrator, or designee initial report to the ty Services Health Care within 24 hours after an reported to the facility."  In the facility's policy revealed, Designee will begin each 24 hours of an allegation of contation, or any injury of investigator will determine if eged to have committed the be suspended immediately en investigation, or if clinical ed in lieu of suspension, and on to assure the safety of all licy (102.052) revealed, or defined as the failure to disupports necessary to	W 1	53			

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W 153	per their company pharm to client #7. A these allegations wafter the incident of considered delayed company policy.  Further interview or management made the Director of Nurs Facility Nurse A on allegations until the investigated.  B. The Director of Note of Not	e administrator and to HCPR colicy to investigate possible dditional interview confirmed ere reported on 8/8/19 a day courred on 8/7/19 and this was reporting according to their  a 8/23/19 confirmed facility the decision to to suspend sing, direct care staff A and 8/22/19 upon learning of these allegations could be further  dursing also failed to report the s to the Administrator in e facility's policy:  of a written statement by the Director of Nursing dated	W 1	53			
	the Director of Ope allegations were no	9 with the Administrator and rations confirmed these treported to the Administrator the Director of Nursing on					

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W 153	Continued From pag 8/8/19.	e 5	W 15	3			
W 154	STAFF TREATMENT CFR(s): 483.420(d)(3		W 15	64			
	The facility must hav violations are thorough	e evidence that all alleged ghly investigated.					
	Based on review of the facility failed to convidence to thorough mistreatment involvinum, #20, #24, #29).	o thoroughly investigate					
	Review on 8/22/19 or Facility Nurse A to the dated 8/8/19 alleged 8/7/19 his Mickey but gastrostomy. When the insert the Mickey But Nurse's hand and sate button back and gastrostomy. Nurse A poked around in client jab the Mickey buttor shoved the sharp entertails.	f written allegations from e Director of Nursing (DON) during client #7's bath on tton was pulled out of his he Facility Nurse A tried to tton, staff A took it out of the id," I'll do it." Nurse A took got it reinserted into the A also alleged that staff A ht #7's gastrostomy trying to h in. She also alleged staff A d of a Q-Tip in the button. signed by Facility Nurse A					
	client #7 dated 4/10/with Severe Develop Dystrophy, Vocal Co	f a medical evaluation for 19 revealed he is diagnosed mental Delays, Cerebellar rd Paralysis, Dysphagia and atory. Additional review of					

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W 154	extension. The med client #7 is to have r (NPO).  Interview on 8/22/19 revealed she had ap Nursing with concer with her replacing a She stated she gave 8/8/19 of these alleg Nursing.  Interview on 8/22/19 been assisting with when his Mickey Bu She stated she cont assist her with puttir into the Gastrostomy revealed facility nurs was having difficulty watched the Nurses Mickey button for cli tried to assist the Nu button away from he very upset but Nurse Mickey Button. Staff What did she [The Nu would she tell on me her?" When asked if her about these allegented the state of the state		W 18	54			

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMM	` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  TAR RIVER  STREET ADDRESS, CITY, STATE, ZIP CODE  498 & 500 SEAN DRIVE  GREENVILLE, NC 27834  ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 154  Continued From page 7 had not been investigated. When asked if she had told the administrator about the allegations, she stated the administrator was away from work for several days and she did not contact her. Additional interview confirmed these allegations were also not reported to Health Care Personnel Registry. The DON stated she had held onto these allegations and asked facility Nurse A to come to her office to talk with her on 8/12 and			34G265	B. WING				
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  W 154  Continued From page 7 had not been investigated. When asked if she had told the administrator about the allegations, she stated the administrator was away from work for several days and she did not contact her. Additional interview confirmed these allegations were also not reported to Health Care Personnel Registry. The DON stated she had held onto these allegations and asked facility Nurse A to come to her office to talk with her on 8/12 and					498 & 500 SEAN DRIVE	1 00/23/2019		
had not been investigated. When asked if she had told the administrator about the allegations, she stated the administrator was away from work for several days and she did not contact her. Additional interview confirmed these allegations were also not reported to Health Care Personnel Registry. The DON stated she had held onto these allegations and asked facility Nurse A to come to her office to talk with her on 8/12 and	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE COMPLETION		
her office. The DON stated she had not interviewed staff A or any other staff in the area following this incident on 8/7/19.  Review of the facility's policy revealed, "The Administrator/Designee will begin each investigation within 24 hours of an allegation of abuse, neglect, exploitation, or any injury of unknown origin. The investigator will determine if the staff member alleged to have committed the act of abuse should be suspended immediately for the duration of the investigation, or if clinical supervision is needed in lieu of suspension, and take necessary action to assure the safety of all people involved."  Additional review of facility policy (102.052) revealed, "Neglect is generally defined as the failure to provide services and supports necessary to protect a person from serious and/or psychological harm. Unintentional neglect with harm is defined as an act of carelessness, omission, accident or distraction that results in a substantiated allegation of neglect whereby there was harm to the person or significant risk of harm."	W 154	had not been inves had told the adminishe stated the adminishe sale gational acome to her office to the sale gations are come to her office to the sale gations are come to her office to the sale gations are office. The DOM interviewed staff A following this incides the sale gation within abuse, neglect, expunknown origin. The staff member at act of abuse should for the duration of the supervision is need take necessary actipated involved."  Additional review or revealed, "Neglect failure to provide senecessary to protect and/or psychologic with harm is defined omission, accident substantiated allegowas harm to the perharm."	tigated. When asked if she strator about the allegations, inistrator was away from work d she did not contact her. It confirmed these allegations ted to Health Care Personnel stated she had held onto a sked facility Nurse A to to talk with her on 8/12 and cility Nurse A did not come to N stated she had not for any other staff in the area and on 8/7/19.  It is policy revealed, "The genee will begin each 24 hours of an allegation of coloitation, or any injury of the investigator will determine if alleged to have committed the did be suspended immediately the investigation, or if clinical led in lieu of suspension, and ion to assure the safety of all facility policy (102.052) is generally defined as the ervices and supports at a person from serious all harm. Unintentional neglect did as an act of carelessness, or distraction that results in a action of neglect whereby there are on or significant risk of	W 15	4			

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W 154	on 8/7/19 were not interview revealed to been thoroughly inverther there may client #7 or other client #8 or management made the Director of Nurse Facility Nurse A on allegations until the investigated.  B. Management fail that direct care staff bed on Friday aftern Monday morning.  Review on 8/22/19 8/8/19 from facility I Nursing revealed that 1. Direct care staff put clients #6, #20, following their return around 3pm until Safe 2. Direct care staff (were putting clients Fridays at 3pm wheeled the properties of t	g client #7 and facility Nurse A reported to him. Additional hese allegations should have restigated by management per y (102.52) to determine have been possible harm to	W 1	54			
	Interview on 8/22/19 confirmed these alle investigated.	9 with the Director of Nursing egations were not					

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OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 498 & 500 SEAN DRIVE GREENVILLE, NC 27834	1 33/25/23 13		
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION		
Interview on 8/23/19 the Director of Opera allegations were not i management.  The Director of Nursia allegations of mistrea thorough investigation not completed by ma this resulted in the factorial provide statutorily maclients in the facility.  STAFF TRAINING PFCFR(s): 483.430(e)(1)  The facility must provinitial and continuing employee to perform efficiently, and competition of the school, staff failed safely transferring clients affected 1 of 5 samplies:  Direct care staff failed safely transferring clients affected 1 of 5 samplies:	with the Administrator and tions confirmed these nvestigated by  Ing failed to report several the the to clients and a nof these allegations was nagement. Subsequently, cility's systemic failure to undated Client Protections to ROGRAM  )  ide each employee with training that enables the his or her duties effectively, etently.  Interest as evidenced by: not met as evide					
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9 Interview on 8/23/19 with the Administrator and the Director of Operations confirmed these allegations were not investigated by management.  The Director of Nursing failed to report several allegations of mistreatment to clients and a thorough investigation of these allegations was not completed by management. Subsequently, this resulted in the facility's systemic failure to provide statutorily mandated Client Protections to clients in the facility.  STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, record review and interviews the facility failed to provide ongoing training to direct care staff specifically involving safely assisting clients during transfers. This affected 1 of 5 sampled clients (#13). The finding	OVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 9 Interview on 8/23/19 with the Administrator and the Director of Operations confirmed these allegations were not investigated by management.  The Director of Nursing failed to report several allegations of mistreatment to clients and a thorough investigation of these allegations was not completed by management. Subsequently, this resulted in the facility's systemic failure to provide statutorily mandated Client Protections to clients in the facility.  STAFF TRAINING PROGRAM  CFR(s): 483.430(e)(1)  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, record review and interviews the facility failed to provide ongoing training to direct care staff specifically involving safely assisting clients during transfers. This affected 1 of 5 sampled clients (#13). The finding is:  Direct care staff failed to follow guidelines for safely transferring clients.  During observations on 8/22/19 in classroom 3 at the school, staff F took client #13 out of his chair used for mealtime and assisted him to the floor.  Direct care staff put her arm around client #13's back and slid him out of his chair onto the floor	OVIDER OR SUPPLIER  34G265  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISO IDENTIFYING INFORMATION)  Continued From page 9 Interview on 8/23/19 with the Administrator and the Director of Operations confirmed these allegations were not investigated by management.  The Director of Nursing failed to report several allegations were not investigated by management. Subsequently, this resulted in the facility.  STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1)  The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.  This STANDARD is not met as evidenced by: Based on observation, record review and interviews the facility failed to provide ongoing training to direct care staff specifically involving safely assisting clients during transfers. This affected 1 of 5 sampled clients (#13). The finding is:  Direct care staff failed to follow guidelines for safely transferring clients.  During observations on 8/22/19 in classroom 3 at the school, staff F took client #13 out of his chair used for mealtime and assisted him to the floor.  Direct care staff full the rarm around client #13's back and slid him out of his chair out shad now the floor.  Direct care staff full the rarm around client #13's back and slid him out of his chair out shad and the floor.		

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W 189	classroom. The sea unfastened. The qu professional (QIDP) client #13 requires a QIDP stated one per but it requires both often tries to turn ar transferred. Further #13 will attempt to use the state of the state o	tbelt in client #13's chair was alified intellectual disabilities was immediately asked if a one person transfer. The erson can transfer client #13 hands because client #13's record revealed glagnoses:  dysplasia, chronic lung my with moderate intellectual he is considered wither review of his individual dated 4/4/19 confirmed client he independence towards has a one person transfer during, to his chair and onto the  D with staff B revealed direct afternoon shift often feel has sponsibilities and sometimes for another staff to assist how person transfers. She have person transfers. She have person transfers and sometimes for another staff to assist have person transfers, she have person transfers and sometimes for another staff to assist have person transfers. She have person transfers, she have person transfers and sometimes for another staff to assist have person transfers, she have person transfers and sometimes for another staff to assist have person transfers, she have person transfers and have	W 1	89			

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TAR RIVE	R				REENVILLE, NC 27834		
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W 189	learning specific tasks training that is needed that staff try to transfer additional assistance.  Interview on 8/23/19 or revealed direct care is problems with staff not transferring guidelines NURSING SERVICES CFR(s): 483.460(c)  The facility must prove	dditional assistance with s. She stated the additional d is not always available and er clients without asking for with the Administrator taff had not reported of consistently following s.	w:				
	Based on record revifacility failed to provid accordance with the riclients (#7) relative to client's gastrosomy tu Nursing services faile of client #7's gastroste was identified.  Review on 8/22/19 of Facility Nurse A to the dated 8/8/19 alleged 8/7/19 his Mickey but the Facility Nurse A tr Button, staff A took it said, "I'll do it." Nurse A poked around in cliented its nurse A poked around in cliented its said.	not met as evidenced by: ew and interviews, the					

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W 331	( (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		W	331			