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 _____	09/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING GEORGE GROUP HOME	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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 111	CLIENT RECORDS CFR(s): 483.410(c)(1) The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure the content of each individual's Restrictive Program/Behavioral Medication Review was accurate for 1 of 3 audit clients (#1). The finding is: Client #1's Restrictive Program/Behavioral Medication Review contained inaccurate information. Record review on 9/3/19 of client #1's Restrictive Program/Behavioral Medication Review completed in August 2019 stated that client #1's behavior objective was implemented on 12/8/2016. In addition, the heading of the review stated it was for the year 2017 and had another residents name that no longer lives in the facility. Client #1 was admitted to the facility on 4/15/19. Interview on 9/4/19 with the program director revealed the information was inaccurate and appeared to be copy and pasted.	W 111	Preparation and execution of the plan of correction does not constitute admission of agreement by the provider or the truth of the facts alleged or conclusion set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. W111 Client #1's Behavior Support Plan was revised on 9/9/2019 to correct the implementation date, the year of review and replace the former client's name with Client #1's name. Plan to prevent re-occurrance: QP will work closely with the Psychologist to ensure accuracy of plans upon completion. QP will carefully review Behavior Support Plans for accuracy prior to filing in charts. Monitoring will be conducted by the PD and QP during routine chart audits reviews.	10/30/2019
W 348	DENTAL SERVICES CFR(s): 483.460(e)(1) The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house	W 348	W348 LPN scheduled a follow-up dental appointment for Client #1 which took place on 9/11/2019.	10/30/2019

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia B. Stevens — TITLE: Program Director — (X6) DATE: 9/25/19

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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W 348	Continued From page 1 or through arrangement. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to follow dental recommendations for treatment of decayed teeth of 1 of 3 audit clients (#1). The finding is: Client #1 did not receive dental treatment as recommended. Review of client #1's record on 9/3/19 revealed a dental exam completed on 6/6/19 that indicated numerous areas of decay that needed to be addressed. A follow-up appointment was conducted on 6/10/19 and 6/26/19 with the next appointment scheduled for 8/13/19 to address more fillings for decayed areas. There was no documentation in the record that this appointment occurred and the decayed areas were addressed. Interview with the facility nurse on 9/4/19 revealed the appointment may have been canceled and rescheduled. However, the facility nurse could not provide documentation to support this. Interview with the program director on 9/4/19 revealed the appointment that was scheduled for 8/13/19 to fill the decayed areas was not done and no follow-up had been completed.	W 348	LPN inserviced staff on 9/11/2019 on the importance of following the appointment protocol and the importance of individuals making appointments as scheduled. LPN will review discharge reports following client appointments, ensure appropiate follow-up and document all efforts to ensure follow-up. Plan to prevent reoccurrance: GHM will assign specific staff to take clients on scheduled appointments. LPN will monitor weekly to ensure compliance and follow-up with the QP and PD to address any cited issues.	10/30/2019
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2) The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces,	W 436		

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W 436	Continued From page 2 and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 2 of 4 audit clients (#1, #4) were taught to use assistive devices and other necessary devices appropriately and make informed choices about their use. 1. Client #4 glasses were not provided as prescribed. Review on 9/3/19 of Client #4's IPP dated 5/8/19 indicated that she wears prescription glasses. Further review visual evaluation dated revealed 8/22/19, "...bilateral spectacles." Observations throughout the survey in the home on 9/3-4/19 revealed that Client #4 was not wearing glasses. Interview on 9/4/19 with the client revealed that she wears glasses, however, she was not sure when she last wore them or where the glasses currently are. Interview on 9/4/19 with the facility nurse revealed that client #4 does have glasses. However, she was not aware they were missing. Interview with staff A revealed she had been employed at the facility for 2 months, but she has not witnessed the client wearing glasses. 2. Client #1 was not prompted to wear her	W 436	W436 On 9/4/2019, Client #4 had her Annual Vision Exams. Per exam results, Client #4 has 20/20 vision and will no longer need to wear glasses. Follow-up in 1-2 years. On 9/11/2019, the LPN inserviced staff on the updated information regarding Client #4's annual vision exam. On 9/11/2019, the LPN inserviced staff on the importance of Client #1 wearing her hearing aids in both ears during waking hours and the impotrance of staff to monitor Client #1 closely and prompt her as needed to wear hearing aids in both ears. LPN will develop a tool for staff to document efforts to prompt Client #1 to wear both hearing aids. Plan to prevent reoccurrance: Randon monitoring will be conducted by GHM, QP and LPN on a weekly bases to ensure compliance.	10/30/2019

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W 436	Continued From page 3 hearing aids. Review on 9/3/19 of client #1's IPP dated 5/8/19 indicated that she wears hearing aids for bilateral hearing loss during all waking hours. Review of client #1's record revealed an audio evaluation dated 5/20/19 that indicated bilateral hearing loss and hearing aids that should be worn in both ears. Observations in the home on 9/3/19 from 5:55pm to 7:25pm revealed that client#1 was wearing one hearing aid in her left ear. Throughout the observations, staff did not prompt client #1to put her hearing aid in her right ear. Observations in the home on 9/4/19 from 6:01am to 8:20am revealed client #1 was wearing one hearing aid in her left ear. Throughout the observations, staff did not prompt client #1 to put her hearing aid in her right ear. Interview on 9/4/19 with the facility nurse revealed that client #1 does have bilateral hearing loss and should be wearing hearing aids in both ears. The facility nurse stated that the batteries were just replaced a few days ago in both hearing aids. She further stated that, staff are suppose to prompt the client to get her hearing aids and put them in her ear(s). The facility nurse confirmed during the observation on 9/4/19 that client #1 was not wearing a hearing aid in her right ear.	W 436		
W 454	INFECTION CONTROL CFR(s): 483.470(i)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections.	W 454		

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W 454	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure a sanitary environment was provided to avoid transmission of infection and to prevent possible cross-contamination. This potentially affected all clients residing in the home. The findings are: Precautions were not taken to promote client/staff health/safety and prevent possible cross-contamination. 1. During meal preparation on 9/3/19 staff C helped several clients in the kitchen. On several occasions, the staff washed her hands only by rubbing the palm and the back of the hands then handle several food items without gloves. Staff C was observed to have long acrylic nails, longer than one inch in length. At no time was the staff observed cleaning under the fingertips or the nail bed. Interview on 9/3/19 with staff C reviewed she is supposed to clean under her fingertips and the nail bed. Interview on 9/3/19 with the qualified intellectual disabilities professional (QIDP) reviewed all staff are supposed to have short nail to be able to effectively clean the hands properly. Review on 9/3/19 of the facility's policy on hand washing protocol revealed, "...vigorously clean fingertips and nail beds." Further review of the policy revealed, "personal grooming...nails should be kept short, cropped and be properly a manicure (1/4" above the tip of the finer.) without extreme colors of nail polish."	W 454	W454 On 9/11/2019, LPN inserviced staff on the importance of universal precautions and proper hand washing techniques during toothbrushing, meal preperation, etc. and RHA's policy as it relates to the use of gloves, handwashing and infection control. GHM inserviced staff on 9/11/2019 on RHA's policy on personal grooming as it relates to the appropraite grooming and length of nails. Plan to prevent reoccurrance: Monitoring will be conducted weekly by the GHM, QP, LPN and PD for the next six weeks and monthly thereafter to ensure compliance.	10/30/2019

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W 454	Continued From page 5 2. During hygiene care on 9/4/19 at approximately 6:13 am, client #5 was in the bathroom with staff D. The staff prompted the client to brush her teeth, the staff then helped the client to brush hand over hand. After the procedure, the staff obtained a piece of paper towel and wiped her hands. The staff then proceeded to helping the client with blow drying her hair. The staff nails were long approximately 3/4" long. At no time did the staff wear gloves or wash her hands. During an interview on 9/4/19, the staff revealed gloves should be worn while brushing teeth or when there is potential of contamination and staff should have washed their hands before proceeding to another activity. During an interview on 9/4/19, the QIDP revealed the staff should have worn the gloves while brushing client teeth and the nails should be 1/4" long above the fingertip.	W 454		
W 473	MEAL SERVICES CFR(s): 483.480(b)(2)(ii) Food must be served at appropriate temperature. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure foods were served at an appropriate temperature. The finding is: Foods were not served at an appropriate temperature. During evening observations in the home on 9/3/19 at 5:46pm, Staff B removed baked chicken	W 473	GHM will inservice staff on food preperation serving guidelines which included the serving times once food has been removed from heating source, appropriate tempatures (hot/cold), the importance of checking food tempatures before food is taken to the table. Plan to prevent reoccurrance: Monitoring will be conducted by the GHM, HS, QP and PD during routine and formal mealtime observations atleast four times a month for three months to ensure compliance.	10/30/2019

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W 473	Continued From page 6 from the oven and placed the baking pan on the counter. At 6:30 pm staff G and client #4 completed preparing gravy and left it on the stove top. At 6:42 pm client #4 was assisted by staff B to transfer rice and green beans to serving bowl. At 6:45 pm client #5 was verbally prompted by staff G to check the food temperature. Further observation revealed the clients started serving their food at 6:54 pm. At no time was the chicken and green beans reheated. Interview on 9/3/19 with staff G revealed they checked the temperature as a policy to make sure food is served at the right temperature. Further interview revealed, "green beans-100's, rice 110 and chicken like 95 degree." At 6:51 pm staff G prompted client #6 to transfer the chicken to serving bowl. Additional observation of a note posted on wall between the oven and the hood revealed, "...hot food 140... cold food 40." Interview on 9/4/19 with the Program Director confirmed the note posted in the kitchen was accurate and staff should be following the posted temperatures. Additional interview indicated hot foods should be served within 15 minutes after removal from the stove or oven.	W 473		

RHA
HEALTH SERVICES, LLC

September 25, 2019

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Mrs. Wambui Karanu:

Enclosed is the Plan of Correction for King George Group Home from the recertification survey completed on 9/4/2019. Please know that we are addressing all items cited during the survey. Please feel free to call me with any questions or concerns.

Sincerely,

Cynthia B. Stevens

Ms. Cynthia B. Stevens, BS, CESP
Program Director
RHA Health Services, LLC
1793 Briley Road
Greenville, North Carolina 27834
(252)-559-0016
cstevens@rhanet.org