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 _____	C 12/02/2020

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 000	INITIAL COMMENTS A complaint and follow up survey were completed on 12/2/2020. Deficiencies were cited as a result of the complaint survey for Intake #NC00171791 and #NC00171810.	W 000		
W 149	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure that all staff received training on the abuse policy. This had the potential to affect all clients in the home. The findings are: Review on 12/2/20 of the facility's October and November 2020 Abuse In-Service training, revealed that Staff A did not attend either class. An additional review of the facility's Incident Report dated 11/13/20, revealed that Staff A had been identified as the alleged perpetrator of physical abuse against client #4. After the facility concluded their investigation on 11/17/20, Staff A was terminated due to a substantiated finding. Interview on 12/2/20 with the Home Manager (HM) revealed that she conducted the abuse training and had 7 staff who attended. She could not offer a reason why Staff A missed the training. Interview on 12/2/20 with the Program Director (PD) revealed that staff receive abuse training at hire in orientation and thereafter, every month at	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W 149	Continued From page 1 their mandatory meetings. She expected staff to make up the training within 7 days if staff were absent the date of training. The PD that she was unaware that Staff A was not participating in their monthly abuse training.	W 149		
W 153	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. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to immediately notify law enforcement and department of social service (DSS) once they initiated an abuse investigation for 1 of 1 audit clients (#4). The finding is: Review on 12/2/20 of the facility's undated Reporting Abuse, Neglect and Exploitation policy referred to the Burt's Law (Senate Bill 445) which stated "that staff ...are required by law to report any instances of abuse, whether intentional or accidental. These organizations are required to report any incident of abuse to authorities within 24 hours." Interview on 12/2/20 with the Program Director revealed that she normally contacted DSS and law enforcement after she completed the 5 days abuse investigation. She further expressed that she was aware that it should be done within 24 hours.	W 153		

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W 252	PROGRAM DOCUMENTATION CFR(s): 483.440(e)(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure all data relative to the accomplishment of Individual Program Plan (IPP) objectives was documented for client #1's Behavior Support Plan (BSP). The finding is: Review on 12/2/20 of client #1's IPP dated 10/8/20 revealed a behavior objective to decrease explosive episodes supported through client #1's BSP. Review on 12/2/20 of client #1's BSP revealed staff are to document behaviors in hourly intervals beginning at 6:00am through 6:00am the next day, repeated daily Monday through Sunday each week. Review of data collected for client #1's BSP revealed the following: - On 11/14/20, no data was collected from 6:00am to 6:00am. - On 11/15/20, no data was collected from 6:00am to 6:00am. - On 11/16/20, no data collected from 6:00am to 8:00am and 4:00pm to 6:00am the following day. - On 11/23/20, no data collected from 8:00am to 4:00pm. - On 11/25/20, no data collected from 4:00pm to 12:00am. - On 11/26/20, no data collected from 10:00am to 1:00pm.	W 252		

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W 252	Continued From page 3 - On 11/28/20, no data collected from 6:00am to 8:00am. - On 11/30/20, no data collected from 12:00am to 6:00am. Interview on 12/2/20 with the Program Director revealed that staff are supposed to document client #1's behaviors in hourly intervals, daily beginning at 6:00am through 6:00am the next day. The Program Director revealed that data is collected even when client #1 is asleep, or staff can write in "sleep" during that time. The Program Director confirmed that client #1's behavior data should have been documented hourly and daily as the BSP indicates.	W 252		