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	Preperation and execution of this 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 solely because it is required by the provisions of federal and state law.	
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	W 149 The Group Home Manager will ensure that staff receive monthly inservice on RHA's policy # 420.0 as it relates to abuse, neglect and exploitation. Plan to prevent re-occurance: QP will monitor monthly during monthly house meetings to ensure compliance.	1/31/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cynthia B. Stevens — TITLE: Program Director — (X6) DATE: 12/18/20

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 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	W 153 QP will utilize an abuse investigation checklist when conducting internal investigations to ensure all notifications to the Department of Social Services and Greenville Police Department are made are made within the required 24 hour wondow. QP will update the PD once notifications has been made. Plan to prevent re-occurrance: Monitoring will be conducted by the PD to ensure compliance.	1/31/2021

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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	W 252 Group Home Manager/BA will inservice staff on the importance of documenting residents' behaviors as outlined in the resident's Behavior Support Plan. Plan to prevent re-occurrance: Monitoring will be conducted randomly several times a monthby the QP and PD to ensure compliance.	1/31/2021

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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		

RHA
HEALTH SERVICES, LLC

December 18, 2020

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

Dear Mr. Esther Moore:

Enclosed is the Plan of Correction for King George Group Home from the complaint survey completed on 12/2/2020. Please know that we are addressing all items cited during the survey. Please feel free to call me with any questions or concerns.

Sincerely,

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