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 03/01/2023

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 survey was completed on March 1, 2023 for Intake #NC00198458. A deficiency was cited.	W 000		
W 154	STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(3) The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on record review and interviews, the facility failed to ensure all allegations were thoroughly investigated. The finding is: Review of information following an Involuntary Commitment hospitalization on 2/8/23 revealed that on 2/9/23 when client #1 was told she was being discharged she reported to hospital staff that she did not want to return to the group home because they physically hit her. The doctor did note there were no bruises or marks observed by medical staff. Interview on 3/1/23 with the qualified intellectual disabilities professional (QIDP) and the home manager (HM) revealed that the staff was made aware of the allegations when the group home staff went to pick client #1 up from the hospital on 2/9/23. The QIDP and HM both denied client #1 having reported any allegations of abuse to them. Interview on 3/1/23 with the facility's program director revealed she was made aware of the allegations. The program director confirmed an investigation should have been initiated immediately after learning of the allegations made at the hospital by client #1 on 2/9/23.	W 154		

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