DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 11/07/2025

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 11/7/25 for intake #NC00234435. The intake was substantiated, and deficiencies were 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 interview and record review, the facility failed to ensure one allegation of neglect reported was thoroughly investigated. This affected 1 of 1 discharged client (dc #1). The finding is: Review on 11/7/25 of incident reports for September revealed multiple reports on 9/24/25 revealing at 5:33am, dc #1 was sleeping and refused to get up for school. After rising from the bed, she fell to the floor and began screaming. At 6:47am, she was in the bathroom getting dressed and asked to take a shower. She refused and began to curse, as well as smear feces. She then went to the living room, where she was asked to complete chores before going to school. She did not comply, became verbally aggressive, and was asked to calm down in her room. She then exhibited target behaviors of physical aggression, self-injury, property destruction, throwing objects, cursing, and elopement from 6:47am to 7:20am. Local authorities arrived at the home at 7:20am, and she was taken to the hospital. She remained at the hospital until she was discharged from the facility and did not return to the home. Review on 11/7/25 of dc #1's psychology notes, dated 9/24/25 at 7:11am, revealed the psychologist had received team texts regarding	W 154		

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

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 154	Continued From page 1	W 154		

dc #1's behaviors in the home. Per the administrator, she had attacked several housemates for no reason. Law enforcement was reportedly in route to assist. Use of crisis medication was discussed in the team text conversation. However, dc #1 refused to take any medications. At 7:32am, the home manager reported she had a cut on her right hand from a piece of glass from a picture in a peer's bedroom. The emergency management services and police were currently in the home. At 8:26am, she was taken to the hospital.

Review on 11/7/25 of Child Protective Services (CPS) report, dated 9/26/25, revealed an allegation of abuse from dc #1 in which a staff had sat on her, causing her to throw up and cut to her hand.

Review on 11/7/25 of facilty investigations for September revealed no investigations from 9/20/25 to 9/30/25.

Interview with the Qualified Intellectual Disabilities Professional (QIDP) revealed dc #1 was discharged from the home while at the hospital on 9/24/25, although they had planned to discharge her for some time. The QIDP became aware of allegations of abuse concerning a staff sitting on dc #1 in the home, causing her to throw up and be injured, when CPS had arrived at the home to investigate on 9/27/25. However, she admitted that the facility had not completed an investigation into the matter because it had been reported at the hospital, and dc #1 was discharged. In addition, the name of the accused staff was unknown to the QIDP, and no one worked at the home with that name.

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W 203	Continued From page 2	W 203		
W 203	ADMISSIONS, TRANSFERS, DISCHARGE CFR(s): 483.440(b)(5)(i) At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure a final summary for 1 of 1 discharged client (dc #1) was developed. The finding is: Review on 11/7/25 of a dc #1's psychology note, dated 9/24/25, stated the administrator secured approval to discharge dc #1 from the home after being taken to the hospital as opposed to waiting until the "earlier discussed 10/13/25 discharge date". The psychologist agreed this was necessary due to safety risks in the home. The administrator anticipated a meeting to be planned between hospital staff, dc #1's guardian, the Managed Care Organization (MCO), and the administrative team. On 9/24/25, the emergency room nurse stated there had been no discussion of discharge. Further review revealed on 9/25/25, the emergency room psychiatrist stated dc #1 would not be discharged at this time, but a group home setting is also not appropriate for her. The hospital staff would meet to discuss appropriate alternative placement. Review on 11/7/25 of the Qualified Intellectual Disabilities Professional (QIDP) notes, dated 9/24/25, revealed the guardian was provided with discharge paperwork and dc #1 was transported to the hospital. The QIDP informed the guardian	W 203		

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W 203	Continued From page 3 that she had not made the hospital aware, but due to safety concerns, the team had come to an agreement of an immediate discharge. The guardian stated she understood. The MCO required formal discharge notice. The QIDP informed the team of speaking with the hospital doctor, and the team was informed that he stated dc #1's current placement was not appropriate. However, in-patient treatment was also not appropriate. Review on 11/7/25 of letter correspondence revealed on 8/14/25, the guardian and MCO were notified that dc #1 would be discharged on 10/13/25. On 9/24/25, the guardian and MCO were sent a formal notification of dc #1's immediate discharge, effective on 9/24/25. Review on 11/7/25 of dc #1's record revealed no evidence a final discharge summary had been completed. Review on 11/7/25 of facility discharge policy, dated July, 2020, revealed in extreme cases in which the team believes a move is necessary, the designated appropriate clinical team member or administrator will complete the discharge summary and plan. It will be written as soon as practical but no later than 30 calendar days from the time of discharge. The plan will contain recommendations for further services. However, the plan may not be required when it is not feasible because of an unanticipated discontinuation of the client's treatment. With consent of the guardian, professionals responsible for the plan shall contact appropriate agencies at the individual's destination. If a decision to suspend or terminate services is made, the facility will provide ample notice as	W 203		

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W 203	Continued From page 4 required by the governing authority. Interview with the QIDP revealed dc #1 was discharged on 9/24/25. However, no discharge summary was completed. The facility does have a discharge form, but it was not filled in. The facility had notified the guardian that dc #1 would be discharged on October 13, 2025 in August. They then notified the guardian of immediate discharge on 9/24/25.	W 203		