

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

PRINTED: 10/13/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G018</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/07/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>SPRINGDALE LANE GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>934 SPRINGDALE LANE GASTONIA, NC 28052</b>	
(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 186	<p><b>DIRECT CARE STAFF</b> CFR(s): 483.430(d)(1-2)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, review of records and interviews the facility failed to provide sufficient direct care staff to manage and supervise 5 of 5 clients appropriately (#1, #2, #3, #4 and #5). The finding is:</p> <p>Observation in the group home on 10/7/21 at 12:00 PM revealed 2 staff on shift with 5 clients. Continued observation revealed Staff B to leave the group home with (#1, #4) clients for a community walk. Further observation revealed staff A to remain at the group home with (#2, #3, #5) clients.</p> <p>Review of internal records on 10/7/21 revealed multiple staffing schedules from 8/2021-10/6/2021 to reflect shift coverage at various times to be covered by (1) staff. Continued review of internal documents revealed time sheets to further indicate various shifts from 8/2021-10/6/2021 to reflect shift coverage by (1) staff. A random sample of dates reflecting staff schedule and time record shortage (8/1/21, 8/28/21, 8/30/21, 9/3/21, 9/7/21, 9/9/21, 9/11/21, 9/12/21, 10/2/21) was provided to administration with no ability to provide evidence the staffing ratio was covered on the identified dates.</p> <p>Interview on 10/7/21 with staff A in the group</p>	W 186	<p>A minimum of 8-10 hours per day, 2 direct care staff will work in the home per 5 individuals served. Staff are spread strategically throughout the day. Staff are supplemented with clinical staff and with licensed recreational therapy staff who work with the individuals in the home or community.</p> <p>As discussed during the exit meeting, the staffing crisis is real and severely restricts the ability to staff 2-3 staff throughout the entire day. During the period of July through September 2021, GRS human resources processed 295 applications for employment. Of those, 114 returned calls for interviews. Only 15 applicants accepted employment. Human Resources and Management will continue to recruit staff strenuously until the appropriate number of staff are hired and the ability to staff 2-3 staff for 10-14 hours per day can be achieved.</p> <p>The house manager is responsible for scheduling the appropriate number of staff. The Operations Manager of the ICF section is responsible for monitoring staff schedules at least twice per week to assure the minimum staff are scheduled and working.</p>	12/07/21

**RECEIVED**  
**OCT 27 2021**  
**DHSR-MH Licensure Sect**

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Paula Nettles*

*Executive Director 10/20/21*

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 186	Continued From page 1 home revealed the staff to work both 1st and 2nd shifts. Continued interview with staff A revealed she had worked multiple shifts alone at times due to staff shortage. Staff A further verified (2) staff were needed on shift due to behavior problems of various clients and the restricted independence of client #3 in a wheelchair. Interview with the facility qualified intellectual disabilities professional (QIDP) and administration staff on 10/7/21 verified a required ratio in the group home of (2) staff to the (5) clients in facility.  Interview with facility administration on 10/7/21 confirmed that the facility had been experiencing staff shortage. Further interview with administration verified through review of internal documents, that the facility had a number of shifts at various times where one staff was responsible for all (5) clients residing in the facility. Subsequent interview with administration verified that she was unaware of the significant number of shifts that reflected insufficient staffing coverage.	W 186		



NC DEPARTMENT OF  
**HEALTH AND  
HUMAN SERVICES**

ROY COOPER • Governor  
MANDY COHEN, MD, MPH • Secretary  
MARK PAYNE • Director, Division of Health Service Regulation

October 14, 2021

Ms. Darlene Norton, Executive  
Gaston Residential Services, Inc.  
905-A N. New Hope Road  
Gastonia, NC 28054

Re: Complaint Investigation Survey October 7, 2021  
Springdale Lane Group Home; 934 Springdale Lane; Gastonia, NC 28052  
Provider Number 34G018  
MHL# 036-069  
E-mail Address: [dnorton@grsinc.org](mailto:dnorton@grsinc.org)  
Complaint Intake #NC00180880

Dear Ms. Norton:

Thank you for the cooperation and courtesy extended during the complaint investigation survey completed on October 7, 2021.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practice(S) that does/do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

**Type of Deficiencies Found**

- Standard level deficiencies were cited.

**Time Frames for Compliance**

- Standard level deficiency must be **corrected** within 60 days from the exit of the survey, which is December 7, 2021.

**What to include in the Plan of Correction**

- Indicate what measures will be put in place to **correct** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to **prevent** the problem from occurring again.
- Indicate **who will monitor** the situation to ensure it will not occur again.
- Indicate **how often** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

**MENTAL HEALTH LICENSURE & CERTIFICATION SECTION**

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION**

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603  
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718  
[www.ncdhhs.gov/dhsr](http://www.ncdhhs.gov/dhsr) • TEL: 919-855-3795 • FAX: 919-715-8078

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER



10/14/21  
Springdale Lane  
Ms. Darlene Norton

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

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

Please be advised that additional W tags may be cited during the Life Safety Code portion of the recertification survey.

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call me at 704-572-1786.

Sincerely,



Lisa Jones  
Facility Compliance Consultant I  
Mental Health Licensure & Certification Section

Enclosures

Cc: QM@partnersbhm.org  
dhhs@vayahealth.com