PRINTED: 03/02/2025 FORM APPROVED

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER  CABARRUS COUNTY GROUP HOME 5  (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  106 SOUTH FRANKLIN STREET  CHINA GROVE, NC 28023  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPRESS)  COMPRESS, CITY, STATE, ZIP CODE  106 SOUTH FRANKLIN STREET  CHINA GROVE, NC 28023	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	S (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
CABARRUS COUNTY GROUP HOME 5  106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  106 SOUTH FRANKLIN STREET CHINA GROVE, NC 28023  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DAY  DAY  OF THE PROVIDER'S PLAN OF CORRECTION COMP DAY DEFICIENCY DEFICIENCY  OF THE PROVIDER'S PLAN OF CORRECTION COMP DAY DEFICIENCY DEFICIEN		MHL080-164	B. WING		02/:	02/25/2025	
CABARRUS COUNTY GROUP HOME 5  CHINA GROVE, NC 28023  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  REGULATORY OR LSC IDENTIFYING INFORMATION)  CHINA GROVE, NC 28023  ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMP DAY DEFICIENCY)  COMP DAY DEFICIENCY							
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V 000 INITIAL COMMENTS V 000	V 000 INITIAL COMMENTS		V 000				
An annual survey was attempted on 2/25/25. According to the Qualified Professional, there are no clients being served at the facility. The last time clients were served at the facility was 5/14/24.  The facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disabilities.  Interview on 2/25/25 with the Qualified Professional revealed:  On 5/14/24, a tree fell on the facility which necessitated an emergency placement of the clients to other locations which included sister facilities  All clients remained in their emergency placements as of 2/25/25  She could not provide any information as to when the clients would be able to return to the facility  Review on 2/25/25 of the a Emergency Relocation Form (ERF) completed by an Administrative Assistant/Billing Analyst for the agency which oversaw the operation of the facility revealed:  On 5/14/24, the clients from the facility had to be moved due to a storm which "caused a tree to fall on back side of group home."  There was a power outage at the facility with "rain continuously raining in the group home."  Although, the expected date of return of clients to the facility was documented as "to be determined," the agency did not plan to submit a change of location application based on the information listed on the ERF	An annual survey According to the 0 no clients being s time clients were 5/14/24.  The facility is licer category: 10A NC Living for Adults w  Interview on 2/25/ Professional reve - On 5/14/24, a necessitated an e clients to other loo facilities - All clients rem placements as of - She could not when the clients w facility  Review on 2/25/2: Relocation Form ( Administrative As agency which over revealed: - On 5/14/24, th be moved due to fall on back side of - There was a p "rain continuous - Although, the clients to the facili determined," the a change of location	rvey was attempted on 2/25/25. The Qualified Professional, there are a served at the facility. The last ere served at the facility was dicensed for the following service. NCAC 27G .5600C Supervised atts with Developmental Disabilities. All 25/25 with the Qualified evealed: All a tree fell on the facility which an emergency placement of the are locations which included sister remained in their emergency of 2/25/25. In not provide any information as to not served any information of the facility and the expected by an expected by an expected by an expected at the facility with any information of the facility was documented as "to be the agency did not plan to submit a pation application based on the					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE