

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL041-607	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 05/28/2025
NAME OF PROVIDER OR SUPPLIER JANE STREET GROUP HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 JANE STREET GREENSBORO, NC 27407		
(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) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>An annual ad complaint survey was completed on May 28, 2025. The complaint was unsubstantiated (Intake #NC00230275). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.</p> <p>This facility is licensed for 5 and has a census of 5. The survey sample consisted of audits of 3 current clients.</p>	V 000		
V 367	<p>27G .0604 Incident Reporting Requirements</p> <p>10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information:</p> <p>(1) reporting provider contact and identification information;</p> <p>(2) client identification information;</p> <p>(3) type of incident;</p> <p>(4) description of incident;</p> <p>(5) status of the effort to determine the</p>	V 367		

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

TITLE

(X6) DATE

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V 367	Continued From page 1 cause of the incident; and (6) other individuals or authorities notified or responding. (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever: (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable. (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including: (1) hospital records including confidential information; (2) reports by other authorities; and (3) the provider's response to the incident. (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C .0300 and 10A NCAC 27E .0104(e)(18). (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided. The report shall be submitted on a form provided by the Secretary via electronic means and shall	V 367		

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V 367	<p>Continued From page 2</p> <p>include summary information as follows:</p> <p>(1) medication errors that do not meet the definition of a level II or level III incident;</p> <p>(2) restrictive interventions that do not meet the definition of a level II or level III incident;</p> <p>(3) searches of a client or his living area;</p> <p>(4) seizures of client property or property in the possession of a client;</p> <p>(5) the total number of level II and level III incidents that occurred; and</p> <p>(6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure Level II incident reports were submitted to the Local Management Entity/Managed Care Organization (LME/MCO) within 72 hours as required. The findings are:</p> <p>Record review on 5/23/25 of client #1's record revealed: -Date of Admission: 8/23/05; -Diagnoses: Down Syndrome; Intellectual Disability, mild; Adjustment Disorder D/O with mixed disturbance of emotional conduct; Hypertension; S/P Right Proximal Humerus Fracture; Type II Diabetes; Dyslipidemia; and Constipation;</p>	V 367		

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V 367	<p>Continued From page 3</p> <p>-On 11/21/24, client #1 set fire to the facility's siding; -On 4/2/25, client #1 set fire to the facility's wooden fence and a tree in the back yard.</p> <p>Review on 5/27/25 of the Incident Response Improvement System (IRIS) from November 1, 2024 to May 23, 2025 revealed: -Incident report dated 11/21/24 was submitted on 4/16/25; -Incident report dated 4/2/25 was submitted on 4/16/25.</p> <p>Interview on 5/27/25 with client #1 revealed: -"...I want to be free from everybody;" -"I was bored and started the fire;" -"The house is so boring, and he does not like being in a group home;" -"On 4/2/25, I went out for my unsupervised time (in community) and when I returned to the group home. I got bored again. When I get back from doing my own thing, I'm bored out of my mind."</p> <p>Attempted interview with client #1's legal guardian on 5/28/25 revealed: -He was notified about the incidents with client #1 starting the fires by the Qualified Professional (QP); -He is aware of client #1's most recent behaviors of leaving the facility without permission; -He had been client #1's legal guardian since 2017, approximately 8 years; -There had been a lot of behavior issues with client #1, while residing with the licensee. No specific details were provided.</p> <p>Interview on 5/27/25 and 5/28/25 with the QP revealed: -"I thought I submitted the reports (11/21/24 and 4/2/25) on time, but I did not receive the thumbs</p>	V 367		

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V 367	Continued From page 4 up confirming submission." Interview on 5/28/25 with the Regional Administrator revealed: -"Logistical training issues", with the QP.	V 367		
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observations and interviews, the facility was not maintained in an attractive, and orderly manner. The findings are: Observation on 5/23/25 at approximately 3:59pm revealed: Gutters: -The gutters in the front, back, and left side of the facility had pine needles and twigs sticking out the gutters. Siding: -The siding underneath the bedroom window was burnt and melted approximately twelve centimeters wide and 12 centimeters long; -There was a black growth built up on the siding in the back of the facility. Hallway: -The carpet had a huge stain from the bathroom door into the main hallway. The stain was approximately 30 centimeters wide and 30 centimeters long.	V 736		

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V 736	<p>Continued From page 5</p> <p>Bathroom: -The paint was peeling off the doors and drawers of the vanity.</p> <p>Interviews on 5/23/25 and 5/27/25 with client #1 revealed: -The siding was set on fire on 11/21/24; -He was unsure of how long the vanity in his bathroom had been that way. He was unaware of how long the carpet was stained.</p> <p>Interview on 5/23/25 with client #2 and client #3 revealed: -Client #2 and client #3 stated being unaware of the maintenance needs of the facility.</p> <p>Interviews on 5/23/25 and 5/27/25 with staff #2 revealed: -The vanity in the bathroom had previously been replaced in 2024. Client #1 had turned the water on and walked off, leaving the water running into the bathroom floor and hallway; -Staff thought there was a leak in the facility causing the stain in the hallway. The maintenance man assured the staff that there was no leak; -The stain in the hallway had been there for a while. The licensee had been attempting to get the carpet replaced, "for a long time."</p> <p>Interview on 5/27/25 with the Qualified Professional revealed: -Since he was hired, "[RHA] and the [Homeowner] had the carpet shampooed and the stain will not come out;" -The licensee had been working with the homeowner on getting the carpet issue resolved for approximately seven months.</p>	V 736		