STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G248	A. BUILDING _____ B. WING _____	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLINGSWOOD GROUP HOME	214 HOLLINGSWOOD DRIVE STATESVILLE, NC 28677

(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 104	GOVERNING BODY CFR(s): 483.410(a)(1) The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the governing body and management failed to exercise general policy and operating direction over the facility by failing to ensure routine cleaning, repairs and maintenance at the group home were completed in a timely manner, affecting 6 out of 6 clients (#1, #2, #3, #4, #5, #6). The finding is: Observations throughout the 9/9/25 - 9/10/25 survey revealed several repairs needed inside the group home to include broken dining room furniture, a missing toilet tank cover, mold on the walls and ceiling of a client bathroom, a strong odor of urine in the home and a general need for deep cleaning in the whole home. Review of records on 9/108/25 revealed maintenance work orders submitted by the facility staff as follows: Broken/missing toilet tank cover (6/10/25, 6/19/25, 8/5/25), broken dining room furniture (6/19/25, 8/5/25) Interview with the qualified intellectual disabilities professional (QIDP) on 9/10/25 confirmed these items are broken and/or in need of cleaning, repair or replacement and that work orders have been submitted to the provider but no action has been taken on them.	W 104	W104 The business manager will in-service the maintenance coordinator on completing work orders in a timely manner. The clinical team will complete environmental assessments 2x a week for a period of 30 days and then on a routine basis to ensure all work orders are completed. In the future, the maintenance coordinator will ensure all work orders are completed.	11/9/25
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during	W 130		

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

IDD Regional Administrator 9/17/25

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 130	Continued From page 1 treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to assure privacy for 1 of 6 clients (#2), during care and treatment. The finding is: Observations in the group home on 9/10/25 revealed client #2 to exhibit behaviors previously identified in a behavior support plan dated 4/1/24. Continued observation revealed staff A to discuss client #2's behaviors with the surveyor, another client, and the home manager in the common area of the home and within earshot of client #2. Interview with the qualified intellectual disabilities professional (QIDP) on 9/10/25 confirmed that all clients should be given privacy during care and treatment.	W 130	W130 The behavior analyst will in-service all staff on client #2's BSP. The clinical team will complete interaction assessments 1x a week for a period of 30 days and then on a routine basis to ensure client #2's BSP is followed as written. In the future, the behavior analyst will ensure all staff are trained on BSPs.	11/9/25
W 191	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(2) For employees who work with clients, training must focus on skills and competencies directed toward clients' behavioral needs. This STANDARD is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure staff were sufficiently trained with respect to client #2's behavioral needs. The finding is : Observations in the home on 9/10/25 revealed client #2 to engage in behaviors previously identified in a behavior support plan (BSP) dated 4/1/24, to include using loud vocalizations to gain the attention of staff, using inappropriate language, yelling, complaining and refusing staff prompts. Continued observation revealed staff A to respond to client #2's behaviors by arguing with	W 191		

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W 191	Continued From page 2 client #2 as she was moving around the kitchen and refusing client #2's request to eat her breakfast at the kitchen bar instead of the dining room, where she believed another client was staring at her. Further observation revealed that client #2 became more agitated as a result of staff A's response to her behavior and that client #2 eventually began to yell at and threaten another client. Review of records on 9/10/25 revealed client #2's BSP which states that, in response to client #2's behaviors described above, staff should be within a normal conversational distance of client #2, use a calm, moderated, slow voice when engaging with client #2, encourage client #2 to be calm and slow down when needed, and stand still when engaging with client #2. Continued record review revealed a person-centered plan (PCP) for client #2 dated 2/19/25 which states that client #2 should be allowed the option to eat at the kitchen bar when she is having difficulty during meal times. Interview with the home manager (HM) and the qualified intellectual disabilities professional (QIDP) confirmed that client #2's BSP and PCP are current and that all staff should be sufficiently trained to provide the behavioral support necessary for client #2.	W 191	W191 The Qualified Professional will in-service all staff on the PCP of client #2. The clinical team will monitor through interaction assessments 1x a week for a period of 30 days and then on a routine basis to ensure client #2's PCP is followed as written. In the future, the QP will ensure all staff are trained on PCPs.	11/9/25
W 249	PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number	W 249		

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W 249	Continued From page 3 and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that 2 clients (#2, and #6) received a continuous active treatment program as identified in their program plans. The findings are: A. The facility failed to ensure that client #2 was provided with the services identified in her person-centered plan (PCP), behavior support plan (BSP) and occupational therapy (OT) guidelines. For example: Observations in the home on 9/10/25 revealed client #2 to engage in behaviors previously identified in a behavior support plan (BSP) dated 4/1/24, to include using loud vocalizations to gain the attention of staff, using inappropriate language, yelling, complaining and refusing staff prompts. Continued observation revealed staff A to respond to client #2's behaviors by arguing with client #2 as she was moving around the kitchen and refusing client #2's request to eat her breakfast at the kitchen bar instead of the dining room, where she believed another client was staring at him. Further observation revealed that client #2 became more agitated as a result of staff A's response to her behavior and that client #2 eventually began to yell at and threaten another client. During observations of the morning medication pass, Staff A was observed to punch all of client #2's medications and pour water for client #2 without offering client #2 the	W 249	W249 A&B The habilitation specialist will in-service all staff on the programs of client's 2 and 6. The QP will in-service all staff on the PCP of client #6. The behavior analyst will in-service all staff on the BSP of client #6. The clinical team will monitor through interaction assessments 1x a week for a period of 30 days and then on a routine basis to ensure PCPs, BSPs, and programs are followed as written. In the future, the clinical team will ensure all staff are trained on the programs, PCPs and BSPs.	11/9/25

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W 249	Continued From page 4 opportunity to participate in the medication pass. Review of records on 9/10/25 revealed client #2's BSP which states that, in response to client #2's behaviors described above, staff should be within a normal conversational distance of client #2, use a calm, moderated, slow voice when engaging with client #2, encourage client #2 to be calm and slow down when needed, and stand still when engaging with client #2. Continued record review revealed a person-centered plan (PCP) for client #2 dated 2/19/25 which states that client #2 should be allowed the option to eat at the kitchen bar when she is having difficulty during meal times, and that client #2 can pour water and bring it to the medication room. Interview with the qualified intellectual disability professional (QIDP) on 9/10/25 confirmed that client #2 should be provided with all of the services and supports indicated in the program plans. B. The facility failed to ensure that client #6 was provided with the appropriate supervision according to her program plans. For example: During evening observations in the group home on 9/9/25, client #6 was observed to walk out the front door of the group home without the knowledge of staff. Further observation revealed client #6 to be back in the home. Record review on 9/10/25 revealed a PCP dated 3/12/25 and a BSP dated 4/1/25 which both state that client #6 is a risk to leave the area without notice and that staff should use the "zone schedule" to keep her safe, providing a staff in the home in close proximity to outside doors.	W 249		

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W 249	Continued From page 5 Interview with the QIDP and the home manager (HM) on 9/10/25 confirmed that client #6 is a risk to leave the home without notice and that staff should be aware of her location at all times.	W 249		
W 262	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(i) The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 1 of 6 clients (#1). The finding is: Observations throughout the recertification survey from 9/9/25 - 9/10/25 revealed that the refrigerator and pantry in the home are locked due to food seeking behaviors by two clients. Review of records on 9/10/25 revealed a behavior support plan for client #1 dated 4/1/25 no evidence that the HRC had reviewed, consented to, or monitored the locked refrigerator and pantry or the audio monitor annually, as required. Interview with the Qualified Intellectual Disability Professional (QIDP) on 9/10/25 revealed that signed consent forms could not be located during the survey. Continued interview with the (QIDP) verified HRC rights limitation consent forms for all clients should be updated and signed by the HRC annually.	W 262	W 262 The Regional Administrator will in-service the QP and behavior analyst on completing consents and HRC consents. The clinical team will monitor through monthly CQI meetings and quarterly HRC meetings. In the future, the QP and behavior analyst will ensure all consents are obtained.	11/9/25

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W 263	PROGRAM MONITORING & CHANGE CFR(s): 483.440(f)(3)(ii) The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure that restrictive techniques were reviewed and approved by the legal guardian of clients #6. The finding is: Observations throughout the recertification survey period from 9/9/25 - 9/10/25 revealed that the refrigerator and pantry in the home are locked due to food seeking behaviors by two clients. Review of client #6's record on 9/10/25 revealed a behavior support plan (BSP) dated 4/1/25 which indicates that client #6 is prescribed 2 medications for behavior. Further record review revealed no evidence that the restrictive techniques described were reviewed and approved by client #6's guardian as required. Interview with the Qualified Intellectual Disability Professional (QIDP) on 9/10/25 revealed that consent forms had been sent to the guardian but not returned. Further interview revealed that the QIDP had followed up with the guardian to have the consents returned without success, but that no follow-up efforts had been made since 6/24/25. Continued interview with the (QIDP) verified guardian consent forms for all clients should be updated and signed annually.	W 263	W263 Cross reference W262	11/9/25
W 436	SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)	W 436		

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W 436	Continued From page 7 The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Throughout observations in the group home on 9/9/25 and 9/10/25, client #2 was observed to not wear a splint on her left arm. Further observation revealed that staff never prompted client #2 to wear a splint on her left arm. Further record review revealed an OT evaluation dated 1/13/25 which recommends that client #2 be fitted for a thermoplastic ventral elbow brace to prevent further elbow contracture. Interview with the qualified intellectual disability professional (QIDP) on 9/10/25 revealed that client #2 has not been fitted for an elbow brace. Further interview with the QIDP confirmed that client #2 should be provided with all of the services and supports indicated in the program plans.	W 436	W436 The qualified professional and nurse will be in-serviced by the Regional Administrator on following OT recommendations and ensuring adaptive equipment is readily available as ordered. The clinical team will monitor through interaction assessments 1x a week for a period of 30 days and then on a routine basis to ensure Client #2 has her adaptive equipment. In the future, the clinical team will ensure all People Supported have their prescribed adaptive equipment.	11/9/25