STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL041-603	A. BUILDING: _____ B. WING _____	10/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTER SEALS UCP NC GREENSBORO GROUP HOM	4809 HILLTOP ROAD GREENSBORO, NC 27407

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V 000	INITIAL COMMENTS An annual, complaint and follow up survey was completed on October 2, 2025. The complaint was substantiated (intake #NC00233626). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability This facility is licensed for 6 and has a current census of 5. The survey sample consisted of audits of 3 current clients.	V 000		
V 367	27G .0604 Incident Reporting Requirements 10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (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: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the	V 367		

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V 367	Continued From page 1	V 367		

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

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V 367	Continued From page 2 include summary information as follows: (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to report all level III incidents to the Local Management Entity (LME)/Managed Care Organization (MCO) in the catchment area within 72 hours of becoming aware of the incident. The findings are: Review on 10/2/25 of the North Carolina Incident Response Improvement System (IRIS) revealed: -A level II incident report was submitted on 9/9/25 for an incident that occurred on 9/6/25 for an allegation of neglect against a staff member. -No level III incident report was submitted. Interview on 10/1/25 with client #1 revealed:	V 367		

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-Had to use the bathroom and called for Former Staff #1 (FS #1).
-Had to call several time before FS #1 came to her room.
-"I sat there for over an hour in my pee and it soaked through to the bedsheets."
-"[Staff #2] came in an helped me get cleaned up."

Interview on 10/1/25 with FS #1 revealed:
-Heard client #1 yelling she needed to use the restroom
-Admitted she was asleep on third shift and "dog tired."
-Went to check on client #1 at an unknown time
-"[Client #1] knew she was supposed to be on her side when I change her and she was on her back. I left the room because she was not on her back. I do not think she was wet at that time. I went back in and she had peed the bed, linens and all."

Interview on 10/1/25 with staff #2 revealed:
-Worked at the facility with FS #1 on 9/6/25 to 9/7/25
-Was assisting another client when the incident occurred
-FS #1 was called by client #1 to assist with using the bathroom.
-Observed FS #1 walk into client #1's bedroom
-This was "around 2:30am"
-Staff #2 checked on client at approximately 5:30am
-Observed urine soaked linens
-Assisted client #1 with her personal hygiene.

Interview on 10/1/25 with the Group Home Manager/Qualified Professional revealed:
-Was on vacation when the incident occurred.
-Had been with the Agency for 10 months
-Was not aware allegations against staff were

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V 367	Continued From page 4 level III incidents. -Was made aware of the incident on 9/9/25 and completed a level II incident report and started the internal investigation. -Former Staff #1 was terminated on 9/11/25 due to the allegation of Neglect being substantiated. -Client #1 reported Former Staff #1 left her lying in urine when she asked to go to the bathroom on two separate occasions.	V 367		