

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

47  
PRINTED: 10/31/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  34G206	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/28/2025
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NAME OF PROVIDER OR SUPPLIER  ANSONVILLE GROUP HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007
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(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
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W 104	<p><b>GOVERNING BODY</b> CFR(s): 483.410(a)(1)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, review of records and interviews, the governing body and management failed to exercise general policy and operating direction over the facility by failing to assure facility repairs were conducted in a timely manner. The finding is:</p> <p>Observation of the group home during the 10/27/25 - 10/28/25 survey revealed the large resident bathroom to have minor wall surface damage. Further observation of the bathroom revealed rust on the bottom portion of the shower/toilet grab bar. Continued observation revealed rust on the interior entrance door frame, right and left sides. Subsequent observation of the small resident bathroom revealed rust on the interior door frame, right and left sides. Additional observation revealed the floor surfaces to have heavily soiled corners and area alongside baseboards on the residents' hallways as you exit the living room and enter the kitchen on the opposite side.</p> <p>Review of records on 10/28/25 did not reveal a completed work order for the above mentioned repairs.</p> <p>Interview with the home's qualified intellectual disabilities professional (QIDP) on 10/28/25 verified concern with the condition of the group home. Continued interview revealed the repairs had been reported to maintenance and it was unknown when repairs were to occur.</p>	W 104	<p>A facilities maintenance ticket has been entered. Maintenance will make all repairs. Target completion date: 12/28/2025</p> <p>RM or designee will complete monthly environmental checklist and turn into VP of Operations for the next 4 months. Any issues noted RM or Designee will enter a facilities maintenance ticket for repairs to be completed.</p> <p>Target completion Date: 01/15/2026</p>	
W 129	<b>PROTECTION OF CLIENTS RIGHTS</b>	W 129	<p style="text-align: center;"><b>RECEIVED</b> <b>NOV 19 2025</b> <b>DHSR-MH Licensure Sect</b></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*Kevin Clark, Vice President of Operations*

TITLE  
11/13/2025

(X6) DATE

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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NAME OF PROVIDER OR SUPPLIER  <b>ANSONVILLE GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1215 ANSONVILLE/ POLKTON ROAD ANSONVILLE, NC 28007</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 129	<p>Continued From page 1 CFR(s): 483.420(a)(7)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must provide each client with the opportunity for personal privacy. This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 6 audited clients (#2) was ensured dignity and respect relative to appearance with personal attire. The findings is:</p> <p>Based on observation throughout survey 10/27/25 - 10/28/25 client #2 was observed to ambulate throughout the home with undergarments visible during ambulation and when sitting. Continued observation revealed client #1 to ambulate bented over with an unsteady gait showing her undergarments visible while in prone and seated positions.</p> <p>Review of records on 10/28/25 revealed a individual service plan (IFP) dated 4/23/25. Continued review of the PCP revealed for client #2 a current diagnosis as follows: IDD, severe, Cerebral Palsy, Unspecified ADHD, Seizure DO, hypoxia, dementia and incontinence.</p> <p>Review of record on 10/28/25 revealed a behavior support plan (BSP) dated 6/25/25. Continued review of the BSP revealed the following target behaviors: self-injurious behavior, severe disruptions, inappropriate touching herself, invading others' space and non-compliance.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 10/28/25 revealed client #2's plans are current. Further interview with the QIDP revealed a need to explore with the team</p>	W 129	<p>RTL will retrain all staff on dignity and privacy to include not showing undergarments while ambulating or seating.</p> <p>RTL or designee will complete shift observations 2X weekly for 5 weeks and document on a Monarch Shift observation form.</p> <p>Target Completion Date: 12/28/2025</p>		

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W 129  W 249	Continued From page 2 ways to ensure client #2's dignity and respect. <b>PROGRAM IMPLEMENTATION</b> 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 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 review and interview, the facility failed to ensure 4 of 6 audited clients (#1, #2, #4, and #6) received a continuous active treatment program consisting of needed interventions through formal and informal training opportunities. The findings are:  A. The facility failed to ensure clients (#1, #2, #4, and #6) participated in structured activities for 45 minutes of unstructured time. For example:  Observation in the group home on 10/27/25 from 4:45 PM - 5:30 PM revealed client #1 to sit in the living room watching television, client #2 and #4 to sit at the dining room table or be ambulating throughout the kitchen and dining room and #6 to lay in bed unengaged in any structured activity. Further observation revealed client #2 and #4 to grab surveyors throughout this timeframe and attempt to pull them wherever they wanted. Continued observation revealed staff to verbally prompt clients #2 and #4 to not grab or to let	W 129  W 249	RTL will retrain all staff on active treatment and participation of structured activities.  RTL or designee will complete shift observations 2X weekly for 5 weeks and document on a Monarch Shift observation form.  Target Completion Date: 12/28/2025		

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W 249	<p>Continued From page 3</p> <p>surveyors go but not to offer any formal or informal active treatment to occupy their time for a total of 45 minutes. Additional observations revealed client #1 to sit idle for 45 minutes without any other formal or informal active treatment. Subsequent observation revealed client #6 to lay in her bed for 45 minutes without any formal or informal active treatment.</p> <p>Observations in the group home on 10/28/25 from 7:00 AM - 7:45 AM revealed clients #1, #2 and #4 to sit at the dining room table, color and ambulate without any formal or informal active treatment. Further observation revealed client #1 to be non-compliant regarding instructions to clear the table but staff to not follow through in having him follow any instructions. Continued observations revealed clients #2 and #4 to grab surveyors but to stop the behavior when told "no grabbing" by surveyors as staff provided no formal or informal active treatment. Subsequent observation reveal client #1, #2 and #4 to offered no formal or informal active treatment by staff.</p> <p>Review of records for client #1 revealed an individual service plan (ISP) dated 5/2/25. Continued review of the ISP revealed a diagnosis of Severe IDD and Intermittent Explosive DO. Further review of the ISP revealed the following goals: exercise 30 minutes, brush teeth and dust dresser once a week. Subsequent review of records revealed a behavior support plan (BSP) dated 4/29/25 with the following target behaviors: physical aggression, bossy behavior and invading others personal space.</p> <p>Review of records for client #2 revealed an individual service plan (ISP) dated 4/23/25. Continued review of the ISP revealed the</p>	W 249			

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W 249	<p>Continued From page 4</p> <p>following diagnosis: Severe IDD, Cerebral Palsy, Unspecified ADHD, Seizure DO, hypoxia, dementia and incontinence. Further review of the ISP revealed the following goals: exercise 30 minute, toileting every 1-2 hours, be cooperative, complete tasks and participate in group and leisure activities. Subsequent review of records revealed a behavior support plan (BSP) dated 4/29/25 with the following target behaviors: self-injurious behavior, severe disruptions, in-appropriate touching herself, invading others space and non-compliance.</p> <p>Review of records for client #3 revealed an individual service plan (ISP) dated 3/13/25. Continued review of the ISP revealed the following diagnosis: Mood DO, Insomnia, Depression, and Obesity. Further review of the ISP revealed the following goals: walk on lap around the inside of the home, bathing/shower goal, take his medications daily and put on shirt of choice. Subsequent review of records revealed a behavior support plan (BSP) dated 4/29/25 with the following target behaviors: physical aggression, verbal aggression, self-injurious behavior and property destruction.</p> <p>Review of records for client #6 revealed an individual service plan (ISP) dated 4/30/25. Continued review of the ISP revealed the following diagnosis: Profound IDD, Diabetes Mellitus, Scoliosis, Legal blindness, Hypertension, Mood DO and Premenstrual Syndrome (PMS). Subsequent review of records revealed a behavior support plan (BSP) dated 4/29/25 with the following target behaviors: self-injurious behavior (biting arm) and stripping behavior.</p> <p>Interview with the qualified intellectual disabilities</p>	W 249		
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W 249	<p>Continued From page 5</p> <p>professional (QIDP) on 10/28/25 confirmed clients #1, #2, #4, and #6 should have been engaged in formal an informal active treatment.</p> <p>B. The facility failed to ensure client #2 was provided a gait belt to assist with ambulation. For example:</p> <p>Observations throughout the recertification survey from 10/27/25-10/28/25 revealed client #2 to participate in various activities without her gait belt. Further observations revealed client #2 to ambulate in a forward slumped position with no gait belt or stand by assistance. Observations did not reveal client #2 to wear a gait belt during ambulation throughout the survey.</p> <p>Subsequent observation on 10/28/25 at 8:30AM revealed three gait belts in the staff office. Observations did not reveal client #2 to wear a gait belt.</p> <p>Review of the record for client #2 on 10/28/25 revealed an individual service plan (ISP) dated 6/17/25 and a quarterly nursing assessment dated 9/15/25 which indicated the client should have a gait belt and standby assistance. Review of a nurse's note dated 10/21/25 indicated client #2 had a fall on 10/21/25. Review of a physician's order dated 10/16/25 revealed a gait belt was ordered for client #2.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 10/28/25 verified that client #2 should have a gait belt on and stand by</p>	W 249	<p>RTL will hold a treatment team meeting to ensure that client #2 is not refusing to wear her gait belt. If the treatment team decides to continue to implement the gait belt, RTL will retrain all staff on ensuring that they are using client #2s gait belt when she is ambulating.</p> <p>RTL or designee will complete shift observations 2X weekly for 5 weeks and document on a Monarch Shift observation form.</p> <p>Target Completion Date: 12/28/2025</p>		

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W 249	Continued From page 6 assistance during ambulation in the facility and community. Further interview with the QIDP revealed staff have been trained to ensure client #2 has on a gait belt during ambulation.	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 observation, record review and interview, the facility failed to ensure that restrictive techniques were monitored and reviewed annually by the human rights committee (HRC) for 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is:  Observations throughout the recertification survey from 10/27/25-10/28/25 revealed exterior door alarms on exit doors of the facility. Continued observation revealed the door to chime loudly as staff and clients entered and exited the facility. Further observation revealed locks on two hall closet doors.  Review of facility documentation on 10/28/25 did not reveal current human rights committee (HRC) limitation consents for clients #1, #2, #3, #4, #5 and #6. Continued review of the facility documentation did not reveal hall closet locks, door chimes or alarms to be used as behavior support interventions for the clients.  Interview with the qualified intellectual disabilities professional (QIDP) on 10/28/25 revealed she	W 262	VP of Operations will retrain RTL on HRC requirements and expectations, to include obtaining written consent from the legally responsible person. this will be documented on a Monarch Inservice form.  RTL will ensure that she is monitoring HRC due dates by updating her tracking sheet and sending to VP of Operations monthly, to review during 1:1 supervision.  Target completion date: 12/28/2025	

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W 262	Continued From page 7	W 262		
W 263	<p>was not aware that several clients had expired HRC consents for the door chimes and locked hallway closets.</p> <p><b>PROGRAM MONITORING &amp; CHANGE</b> CFR(s): 483.440(f)(3)(ii)</p> <p>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 review and interview, the facility failed to ensure restrictive techniques were reviewed and approved by the legal guardians for 6 of 6 clients (#1, #2, #3, #4, #5 and #6). The finding is:</p> <p>Observations throughout the recertification survey from 10/27/25-10/28/25 revealed exterior door alarms on exit doors of the facility. Further observation revealed the doors to chime loudly as staff and clients entered and exited the facility. Observations also revealed two locked hall closet doors.</p> <p>Review of facility documentation on 10/28/25 did not reveal updated legal guardian consents for exterior door alarms and locked hallway closets for clients #1, #2, #3, #4, #5 and #6. Further review of facility documentation did not reveal behavior support interventions for the locked hall closet doors for the clients.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 10/28/25 revealed she was not aware that the consents for the door alarms and door locks were not current with the legal guardians' approval and signatures. Further</p>	W 263	<p>VP of Operations will retrain RTL on HRC requirements and expectations, to include obtaining written consent from the legally responsible person. this will be documented on a Monarch Inservice form.</p> <p>RTL will ensure that she is monitoring HRC due dates by updating her tracking sheet and sending to VP of Operations monthly, to review during 1:1 supervision.</p> <p>Target completion date: 12/28/2025</p>	

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W 263	Continued From page 8	W 263			
W 436	interview with the QIDP verified that the consents are to be signed annually.  SPACE AND EQUIPMENT CFR(s): 483.470(g)(2)  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: Based on observations, record review and interview, the facility failed to assure that clients use and make informed choices relative to adaptive equipment as prescribed for 2 of 3 audited clients (#4, #5). The finding is:  Morning observations on 10/28/25 from 7:00AM to 8:30AM revealed client #5 to participate in various activities to include meal prep, setting the table, participating in the breakfast meal and medication administration without her eyeglasses. At no point during the observation did staff prompt client #5 to wear her eyeglasses.  Observations on 10/28/25 from 7:00AM-8:30AM revealed client #4 to participate in various activities to include assisting in the kitchen, setting her table setting, participating in medication administration and participating in the breakfast meal without her eyeglasses. Observations did not reveal staff to prompt client #4 to wear her eyeglasses.  Review of the record for client #5 on 10/28/25 revealed an individual support plan (ISP) dated 6/6/25 which indicated the client is diabetic and	W 436	RTL/OT will retrain all staff on all adaptive equipment at Ansonville and completing daily documentation of the condition of the equipment in each person supported EHR.  RTL or designee will complete shift observations 2X weekly for 5 weeks and document on a Monarch Shift observation form.  Target Completion Date: 12/28/2025		

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W 436	Continued From page 9 should wear her eyeglasses daily. Review of the record for client #5 did not reveal a current vision consult after 3/5/23.  Review of the record for client #4 on 10/28/25 revealed an ISP dated 6/6/25 which indicated client #4 should wear eyeglasses daily. Review of the record for client #4 did not reveal a current vision consult during the survey.  Interview with the qualified intellectual disabilities professional (QIDP) on 10/28/25 revealed client #5 should have an updated annual vision consult especially since the client is diabetic. Further interview with the QIDP verified client #5 should wear her eyeglasses during waking hours.  Interview with the QIDP on 10/28/25 verified client #4 should wear her eyeglasses daily. Further interview with the QIDP revealed staff should have prompted client #4 to wear her eyeglasses during the day.	W 436		
W 480	<b>MENUS</b> CFR(s): 483.480(c)(1)(iv)  Menus must include the average portion sizes for menu items. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure 1 of 6 audited clients (#3) received the appropriate quantity of food relative to their prescribed diet. The finding is:  Observation in the group home on 10/27/25 at 5:45 PM revealed client #3 to participate in the dinner to include the following menued items: taco soup, small crackers, shredded cheese,	W 480	RTL or designee will retrain all staff on diet orders for all 6 clients at Ansonville and following the assigned menu of the group home.  RTL or designee will complete shift observations 2X weekly for 5 weeks and document on a Monarch Shift observation form.  Target Completion Date: 12/28/2025	

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(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 480	<p>Continued From page 10</p> <p>sour cream, sliced strawberries, flavored water and plain water. Continued observation of the dinner meal revealed client #3 to independently serve himself with staff supervision the appropriate serving sizes of the diner meal and to consume 100% of the meal. Further observation revealed client #3 to be offered second portions of the taco soup and strawberries by staff and to consume both in their entirety.</p> <p>Observation in the group home on 10/28/25 at 7:45 AM revealed client #3 to participate in the breakfast meal to include the following menued items: two pancakes, two sausage patties, one teaspoon reduced calorie syrup, apple juice, 2% milk and water. Continued observation of the breakfast meal revealed client #3 to independently serve himself three pancakes and three sausage patties with staff supervision. Further observation revealed client #3 to point continuously at the syrup bottle after receiving his portion of syrup. Subsequent observation revealed staff to pour two additional servings of syrup on his food. Additional observation revealed client to pace back and forth to the kitchen requesting eggs with his breakfast meal which staff did not comply.</p> <p>Review of records for client #3 on 10/28/25 revealed a individual service plan (ISP) dated 3/13/25. Continued review of the ISP for client #3 revealed a current diet as follows: regular consistency NO seconds EXCEPT can have more non-starchy vegetables. No sugary beverages Limited deserts to once a week, offer fruits, diet jello, sugar free pudding lite yogurt limit one serving each meal (bread, potatoes, rice pasta) give one side of extra low fat cheese or 1 oz extra meat with lunch and dinner.</p>	W 480			

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

PRINTED: 10/31/2025  
FORM APPROVED  
OMB NO. 0938-0391

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W 480	Continued From page 11  Interview with the qualified intellectual disabilities professional (QIDP) on 10/28/25 revealed the ISP and diet for client #3 is current. Further interview with the QIDP revealed staff have been trained on client #3's ISP and diet. Continued interview with the QIDP revealed the home has a current copy of all clients' diets in the menu book located in the kitchen accessible to all staff. Subsequent interview with the QIDP revealed staff should have followed client #3's prescribed diet.	W 480			