

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

PRINTED: 02/12/2026  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>34G295</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>02/10/2026</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINEWOOD GROUP HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2101 BEAUTY STREET</b> <b>STATESVILLE, NC 28625</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 000	INITIAL COMMENTS	W 000			
W 156	<p>STAFF TREATMENT OF CLIENTS CFR(s): 483.420(d)(4)</p> <p>The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to complete the Health Care Personal Registry (HCPR) within 5 days as required by state statute for client #2. The finding is:</p> <p>Review of facility documentation during the complaint investigation survey on 2/10/26 revealed a facility investigation summary dated 12/15/25. Further review of the 12/2025 facility investigation revealed an allegation of verbal abuse indicating staff A was accused of being verbally abusive to client #2 while attempting to de-escalate the client's behaviors at the day program.</p> <p>Review of the record for client #2 on 2/10/26 revealed an incident response improvement system (IRIS) report completed on 12/9/25 indicating allegations of verbal abuse. Further review of the 12/9/25 IRIS report indicated notifications were made to the following: Iredell County DSS, legal guardian, facility administrator, and LME/MCO. Review of the IRIS report for client #2 revealed no evidence of HCPR being notified within 5 business days of the findings.</p>	W 156			

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

TITLE

(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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W 156	Continued From page 1 Interview with the Program Manager on 2/10/26 verified that the facility internal investigation involving client #2 started on 12/9/25 and was completed on 12/15/25. Further interview with the Program Manager could not verify if the HCPR was submitted as required.	W 156			
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 record review and interview, the facility failed to ensure staff were adequately trained specific to client #2's behavioral needs. The finding is:  Review of facility documentation during the complaint investigation survey completed on 2/10/26 revealed an incident response improvement system (IRIS) completed for clients (#2) dated 12/9/25 which included allegations of verbal abuse towards the client. Further review of facility documentation revealed a facility investigation summary dated 12/15/25 which indicated that on 12/9/25, staff A was accused of being verbally abusive to client #2 while attempting to de-escalate the client's behaviors at the day program.  Review of the facility investigation summary dated 12/15/25 indicated the following interventions would be completed: staff A would receive corrective action for not using client #2's behavior support plan (BSP) appropriately. Management will "complete routine and unannounced visits to ensure all people supported are treated fairly,	W 191			

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W 191	<p>Continued From page 2</p> <p>which will be documented". Additional training for all staff will be provided relative to person-centered training and BSP training. Further review of facility documentation did not reveal evidence that person-centered and BSP training were completed to all staff as required to ensure clients are treated fairly.</p> <p>Interview with the Program Manager on 2/10/26 verified she was the investigator assigned to complete the facility investigation. Further interview with the Program Manager confirmed the allegations for verbal and physical abuse were unsubstantiated, however staff A received disciplinary action for not using client #2's BSP appropriately. Continued interview with the Program Manager verified that staff A and facility staff should have received person-centered training and BSP training to ensure clients are treated fairly.</p> <p>Interview with the qualified intellectual disabilities professional (QIDP) on 2/10/26 verified that staff A did not receive additional training relative to client #2's BSP or person-centered training prior to returning to work on 12/19/25. Further interview with the QIDP verified that facility staff did not receive additional in-service training relative to client #2's BSP and person-centered training to date.</p>	W 191			