

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL049-145	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 02/25/2026
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NAME OF PROVIDER OR SUPPLIER THE GROVE	STREET ADDRESS, CITY, STATE, ZIP CODE 247 CHESTNUT GROVE ROAD STATESVILLE, NC 28625
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V 000	<p>INITIAL COMMENTS</p> <p>A complaint and follow up sure was completed on 2/25/26. The complaint was unsubstantiated (intake #NC00236023). Deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 5600B Supervised Living for Minors with Developmental Disability.</p> <p>This facility is licensed for 4 and has a current census of 4. The survey sample consisted of audits of 1 current client.</p>	V 000		
V 366	<p>27G .0603 Incident Response Requirements</p> <p>10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS</p> <p>(a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by:</p> <ol style="list-style-type: none"> (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. 	V 366		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE IDD Executive Director 3/31/26	(X6) DATE
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V 366	<p>Continued From page 1</p> <p>(b) In addition to the requirements set forth in Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I.</p> <p>(c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by:</p> <p>(1) immediately securing the client record by:</p> <p>(A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team;</p> <p>(2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows:</p> <p>(A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides,</p>	V 366		

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V 366	<p>Continued From page 2</p> <p>if different; and</p> <p>(D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and</p> <p>(3) immediately notifying the following:</p> <p>(A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604;</p> <p>(B) the LME where the client resides, if different;</p> <p>(C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider;</p> <p>(D) the Department;</p> <p>(E) the client's legal guardian, as applicable; and</p> <p>(F) any other authorities required by law.</p> <p> </p> <p>This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to implement a policy governing their response to Level II incidents as required and</p>	V 366		

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V 366	<p>Continued From page 3</p> <p>failed to immediately notify the Local Management Entity/Managed Care Organization (LME/MCO) within the facility's catchment area of all level II incidents. The findings are:</p> <p>Review on 2/24/26 of the Facility's internal policy on Incident Reporting revealed: -Level II includes: ...Unwanted sexual behavior by a person receiving services that involves a complaint to the provider or a criminal act.</p> <p>Review on 2/24/26 of the Facility's incident online log revealed: -No documentation of the allegation of one client touching another client inappropriate.</p> <p>Interview on 2/24/26 with staff #2 revealed: -Was aware the Child Protective Service was at the facility on 2/11/26. -"Only incident report we do if someone is injured."</p> <p>Interview on 2/25/26 with the Qualified Professional revealed: -Was aware the Child Protective Service was at the facility on 2/11/26. -Was responsible for ensuring investigations and incident reports were completed. -Failed to attend to the health and safety needs of the client involved in the incident. -Failed to determine the cause of the incident. -Failed to develop and implement corrective measures. -Failed to develop and implement measures to prevent similar incidents from occurring. -Failed to assign person(s) to be responsible for implementation of the corrections and preventive measures.</p>	V 366	<p>V 366 The Executive Director will in-service the Program manager on proper notifications when completed a level 2 incident. The Program Manager will in-service all staff on incident reporting and documentation. The Executive Director will monitor through monthly QAPI meetings and then on a routine basis to ensure proper notifications are made for level 2 reports. The clinical team will monitor through interaction assessments 2x a week for a period of 30 days and then on a routine basis to ensure staff are completing documentation and incident reporting. In the future, the Program Manager will ensure proper notifications are made for level 2 reports and all staff are trained on incident reporting and documentation.</p>	4/26/26

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V 736 V 736	<p>Continued From page 4</p> <p>27G .0303(c) Facility and Grounds Maintenance</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner. The findings are:</p> <p>Observation on 2/24/26 at approximately 4:13 pm revealed: -Client #1's bedroom: -The supportive slacks did not attach to the bedframe. -The smoke detector was detached from the base on the wall. -No window covering on window. -TV wall mount rod with no TV attached. -Backyard patio area: -A full size box spring and matters. -On left side of the facility multiple desk chairs, headboard frames, empty cardboard boxes.</p> <p>Interview on 2/24/26 with staff #1 revealed: -The mattress had been on the back porch for a few months. -Client #1 had jumped on the bed, and tore down his blinds to the window. -She confirmed the facility failed to ensure facility grounds were maintained in a safe, clean, attractive and orderly manner.</p> <p>Interview on 2/25/26 with the Qualified Professional revealed:</p>	V 736 V 736	<p>V736</p> <p>The Business Manager will in-service the Maintenance Technician on completing all work orders in a timely manner. The clinical team will monitor through environmental assessments 1x a week for a period of 30 days and then on a routine basis to ensure all work orders are completed and any work needed can be reported. In the future, the maintenance technician will ensure all work orders are completed in a timely manner.</p>	4/26/26

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V 736	Continued From page 5 -The mattress had been on the back porch that long. -The smoke detector had been replaced and repaired several times.	V 736		