PRINTED: 03/16/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL026-876	A. BUILDING: _____ B. WING _____	R 03/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHOGANY	6852 MAHOGANY ROAD FAYETTEVILLE, NC 28314

(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) COMPLETE DATE
V 000	INITIAL COMMENTS An annual and follow up survey was completed on March 2, 2022. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. This facility is licensed for 3 and currently has a census of 3. The survey sample consisted of audits of 3 current clients.	V 000		
V 114	27G .0207 Emergency Plans and Supplies 10A NCAC 27G .0207 EMERGENCY PLANS AND SUPPLIES (a) A written fire plan for each facility and area-wide disaster plan shall be developed and shall be approved by the appropriate local authority. (b) The plan shall be made available to all staff and evacuation procedures and routes shall be posted in the facility. (c) Fire and disaster drills in a 24-hour facility shall be held at least quarterly and shall be repeated for each shift. Drills shall be conducted under conditions that simulate fire emergencies. (d) Each facility shall have basic first aid supplies accessible for use. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift. The findings are: Review on 03/02/22 of facility records for 2021	V 114	DHSR - Mental Health APR 04 2022 Lic. & Cert. Section	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE DAOE (X6) DATE 3/17/22

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V 114	Continued From page 1 revealed: -No fire drill documented on 2nd shift for the 3rd quarter of 2021. -No fire drills documented on 1st and 2nd shift for the 4th quarter of 2021. -No disaster drills documented for 3rd shift during for the 1st quarter of 2021. -No disaster drills documented for 1st and 3rd shift during the 2nd quarter of 2021. -No disaster drills documented for 3rd shift during the 3rd quarter of 2021. -No disaster drills documented for 1st, 2nd and 3rd shift during the 4th quarter of 2021. During interview on 03/02/2022 the Program Manager revealed: -She felt like the drills had been completed on not filed in the correct folder. -She would ensure the drills are completed and documented for each shift. This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 114		

Appendix 1-B: Plan of Correction Form

Plan of Correction	
Division Of Health Services Regulation	United Residential Services of NC, Inc. 6503 Kemper Court Fayetteville, NC 28303

Provider Name:	United Residential Services	Phone:	(910)584-6268
Provider Contact Person for follow-up:	Gerald Nickelberry	Fax:	910-491-1055
		Email:	Unitedresidentialservicesinc@yahoo.com
Facility Address:	Mahogany 6852 Mahogany Rd Fayetteville, NC 28314		
	Survey Date: 3/2/2022		

Finding	Corrective Action Steps	Responsible Party	Time Line
V 114 27G. 0207: This Rule is not met as evidenced by: V 114 Based on record review and interviews, the facility failed to ensure fire and disaster drills were held quarterly and repeated on each shift.	As per rule, at least one fire drill will be conducted on each shift quarterly. At least one disaster drill will be conducted on each shift quarterly. The Facility director shall be responsible for this occurring with oversight from the QP and QA/QI committee. Drills shall be documented and maintained in the log book in the home for regular review by QA/QI.	QA/QI committee QP of URS Facility manager Facility staff	Projected Implementation Date: 3/15/2022 Projected Completion Date: 3/15/2022

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

March 17, 2022

Jessie James
United Residential Services of North Carolina, Inc.
P.O. Box 25928
Fayetteville, NC 28314

Re: Annual and Follow Up Survey completed 03/02/22
Mahogany, 6852 Mahogany Road, Fayetteville, NC 28314
MHL # 026-876
E-mail Address: unitedresidentialservicesinc@yahoo.com

Dear Mr. James:

Thank you for the cooperation and courtesy extended during the annual and follow up survey completed 03/02/22.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- Re-cited standard level deficiency.

Time Frames for Compliance

- Re-cited standard level deficiency must be ***corrected*** within 30 days from the exit of the survey, which is 04/01/22.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records.
Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

MENTAL HEALTH LICENSURE & CERTIFICATION SECTION

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES • DIVISION OF HEALTH SERVICE REGULATION

LOCATION: 1800 Umstead Drive, Williams Building, Raleigh, NC 27603
MAILING ADDRESS: 2718 Mail Service Center, Raleigh, NC 27699-2718
www.ncdhhs.gov/dhsr • TEL: 919-855-3795 • FAX: 919-715-8078

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Gloria Locklear at 910-214-0350.

Sincerely,

Emily Jones, BSW

Emily Jones BSW
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: DHSR@Alliancebhc.org
DHSR_Letters@sandhillscenter.org
Pam Pridgen, Administrative Assistant