Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ′ | E CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|-----------------------|--|------|-------------------------------|--|
| | | | B. WING | | | ₹ | |
| | | MHL044-023 | b. WING | | 07/2 | 21/2022 | |
| NAME OF | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | | |
| DOGWO | OD ACRES | 211 NELL CLYDE, N | IE JOHN DR C 28721 | IVE | | | |
| (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 | | V 000 | | | | |
| | on 7/21/22. Deficie This facility is licens category: 10A NCA | w up survey was completed incies were cited. sed for the following service C 27G .5600C Supervised h Intellectual/Developmental | | | | | |
| | | sed for 3 and currently has a urvey sample consisted of clients. | | | | | |
| V 131 | G.S. 131E-256 (D2) Verification |) HCPR - Prior Employment | V 131 | | | | |
| | REGISTRY (d2) Before hiring h health care facility of health care facility s Personnel Registry | ealth care personnel into a or service, every employer at a shall access the Health Care and shall note each incident propriate business files. | | | | | |
| | facility failed to ensi substantiated findin on the North Carolii Registry (HCPR) pr staff (Staff #1, #2 a The findings are: | et as evidenced by: view and interviews, the ure each staff member had no gs of abuse or neglect listed na Health Care Personnel ior to hire for 3 of 3 audited nd Qualified Professional). | | | | | |

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | | (X3) DATE SURVEY COMPLETED | | | | | | |
|---|--|--|---|--------------------------|-------------------------------|--|--|--|--|--|--|
| | MHL044-023 | B. WING | | | R 21/2022 | | | | | | |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | | | | | | | |
| DOGWOOD ACRES 211 NELLIE JOHN DRIVE CLYDE, NC 28721 | | | | | | | | | | | |
| PREFIX (EACH DEFICIENC | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA | (X5) COMPLETE DATE | | | | | | | |
| -Date of Hire- 7/8/2 -Date of HCPR vei Record review on Professional) revei -Date of Hire- 3/3/2 -Date of HCPR vei Interview on 7/21/2 Resources reveale -She was aware of corrected their prohad been cited at a | 7/21/22 for Staff #2 revealed: 21 rified- 7/15/21 7/21/22 for the QP (Qualified aled: 22 rified- 3/4/22 22 with the Director of Human ed: 6 this issue and had already cess in April 2022 because it | V 131 | | | | | | | | | |

6899

Division of Health Service Regulation STATE FORM

N99L11 If continuation sheet 2 of 2