STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R		
		MHL044-023	B. WING		05/2	3/2024
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
DOGWO	OD ACRES	211 NELLI CLYDE, N	IE JOHN DR C 28721	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	rs	V 000			
	An annual and follow up survey was completed on 5/23/24. Deficiencies were 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 an audit of 3 current clients.					
V 131	G.S. 131E-256 (D2) Verification	) HCPR - Prior Employment	V 131			
	G.S. §131E-256 HEALTH CARE PERSONNEL REGISTRY (d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.					
	facility failed to ensusubstantiated findin on the North Carolin Registry (HCPR) praudited staff (Qualif findings are:	view and interviews, the ure each staff member had no ags of abuse or neglect listed na Health Care Personnel rior to date of hire for 1 of 3 fied Professional) (QP). The				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND I LAN OF CONNECTION			A. BUILDING:			
		MHL044-023	B. WING		05/2	R 3/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
DOGWO	OD ACRES	211 NELL CLYDE, N	IE JOHN DR C 28721	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 131	Continued From pa	ge 1	V 131			
	-HCPR documenta 1/11/24.	tion was not completed until				
	Interview on 5/23/24 with the Human Resources Director revealed: -Was aware of the requirement for the HCPR check to be completed prior to hireIt was just overlooked.					
	This deficiency con must be corrected	stitutes a recite deficiency and within 30 days.				
V 367	27G .0604 Incident	Reporting Requirements	V 367			
	10A NCAC 27G .0604 INCIDENT REPORTING REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall report all level II incidents, except deaths, that occur during the provision of billable services or while the consumer is on the providers premises or level III incidents and level II deaths involving the clients to whom the provider rendered any service within 90 days prior to the incident to the LME responsible for the catchment area where services are provided within 72 hours of becoming aware of the incident. The report shall be submitted on a form provided by the Secretary. The report may be submitted via mail, in person, facsimile or encrypted electronic means. The report shall include the following information: (1) reporting provider contact and identification information; (2) client identification information; (3) type of incident; (4) description of incident; (5) status of the effort to determine the cause of the incident; and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL044-023	B. WING			3/2024
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
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	OD AGREG	CLYDE, N	C 28721			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 367	Continued From pa	ge 2	V 367			
V 307	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 2  (6) other individuals or authorities notified or responding.  (b) Category A and B providers shall explain any missing or incomplete information. The provider shall submit an updated report to all required report recipients by the end of the next business day whenever:  (1) the provider has reason to believe that information provided in the report may be erroneous, misleading or otherwise unreliable; or (2) the provider obtains information required on the incident form that was previously unavailable.  (c) Category A and B providers shall submit, upon request by the LME, other information obtained regarding the incident, including:  (1) hospital records including confidential information;  (2) reports by other authorities; and  (3) the provider's response to the incident.  (d) Category A and B providers shall send a copy of all level III incident reports to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within 72 hours of becoming aware of the incident. Category A providers shall send a copy of all level III incidents involving a client death to the Division of Health Service Regulation within 72 hours of becoming aware of the incident. In cases of client death within seven days of use of seclusion or restraint, the provider shall report the death immediately, as required by 10A NCAC 26C  .0300 and 10A NCAC 27E .0104(e)(18).  (e) Category A and B providers shall send a report quarterly to the LME responsible for the catchment area where services are provided by the Secretary via electronic means and shall include summary information as follows:		V 307			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
	MHL044-023	B. WING			R <b>23/2024</b>
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(1) medicatio definition of a level (2) restrictive the definition of a le (3) searches (4) seizures (4) seizures (5) the total n incidents that occur (6) a stateme been no reportable incidents have occumeet any of the crite (a) and (d) of this R	n errors that do not meet the II or level III incident; interventions that do not meet vel II or level III incident; of a client or his living area; of client property or property in client; umber of level II and level III red; and ent indicating that there have incidents whenever no arred during the quarter that eria as set forth in Paragraphs ule and Subparagraphs (1)	V 367			
Based on record refailed to ensure a Locompleted within 72 Local Management Organization. The find Record review on 5 reports revealed: -On 3/29/24, Client department store w Staff called 911 and emergency department close the wound on refused additional to	view and interview the facility evel II incident report was 2 hours and submitted to the Entity/Managed Care indings are:  //22/24 of internal incident  #1 had a seizure in a local here she fell and hit her head. I she was taken to the nent. Staples were used to her head but Client #1 reatment.				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS  Continued From pa  (1) medicatio definition of a level (2) restrictive the definition of a le (3) searches (4) seizures of the possession of a (5) the total in incidents that occur (6) a stateme been no reportable incidents have occu meet any of the critic (a) and (d) of this R through (4) of this F  This Rule is not me Based on record re failed to ensure a Le completed within 72 Local Management Organization. The fi  Record review on 5 reports revealed: -On 3/29/24, Client department store w Staff called 911 and emergency departm close the wound on refused additional to	PROVIDER OR SUPPLIER  211 NELLICLYDE, N  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.  This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a Level II incident report was completed within 72 hours and submitted to the Local Management Entity/Managed Care Organization. The findings are:  Record review on 5/22/24 of internal incident	STREET ADDRESS, CITY, S  211 NELLIE JOHN DRI CLYDE, NC 28721  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.  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PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  211 NELLIE JOHN DRIVE CLYDE, NC 28721    SUMMARY STATEMENT OF DEFICIENCIES   ID   PROVIDERS PLAN OF CORE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGE  COntinued From page 3   V 367  (1)   medication errors that do not meet the definition of a level II or level III incident; (2)   restrictive interventions that do not meet the definition of a level II or level III incident; (3)   searches of a client or his living area; (4)   seizures of client property or property in the possession of a client; (5)   the total number of level III and level III incidents that occurred; and (6)   a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1) through (4) of this Paragraph.  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PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  211 NELLIE JOHN DRIVE CLYDE, NC 28721  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  (1) medication errors that do not meet the definition of a level II or level III incident; (2) restrictive interventions that do not meet the definition of a level II or level III incident; (3) searches of a client or his living area; (4) seizures of client property or property in the possession of a client; (5) the total number of level II and level III incidents that occurred; and (6) a statement indicating that there have been no reportable incidents whenever no incidents have occurred during the quarter that meet any of the criteria as set forth in Paragraphs (a) and (d) of this Rule and Subparagraphs (1)  This Rule is not met as evidenced by: Based on record review and interview the facility failed to ensure a Level II incident report was completed within 72 hours and submitted to the Local Management Entity/Managed Care Organization. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMF	(X3) DATE SURVEY COMPLETED	
MHL044-023		B. WING			R <b>05/23/2024</b>	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
DOGWOOD ACRES 211 NELLIE CLYDE, NO			IE JOHN DR IC 28721	IVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
V 367	improvement systemevealed: -There was no report on or about 3/29/24 Interview on 5/23/24 revealed: -The former qualified facility was responsive reportAn IRIS report coulling the system of the sy	m) reports for Client #1 ort for the facility or Licensee d with the Executive Director ord professional (QP) for that lible for completing the IRIS	V 367			

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