STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL044-023	A. BUILDING: _____ B. WING _____	R 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOGWOOD ACRES	211 NELLIE JOHN DRIVE CLYDE, NC 28721

(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 A complaint and follow up survey was completed on November 26, 2024. The complaint was substantiated (Intake #NC00223882). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised Living for Adults with Developmental Disability. This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 1 current client.	V 000		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name; (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and	V 118		

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V 118	Continued From page 1 (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered as prescribed on the written order of an authorized person affecting 1 client (Client #1). The findings are: Review on 11-20-24 and 11-22-24 of Client #1's record revealed: -Date of Admission: 3-1-16. -Diagnoses: Mild Intellectual Developmental Disability, Post Traumatic Stress Disorder, Epilepsy, Dementia, Traumatic Brain Injury, and Unspecified Mood Disorder. -Physician's orders: -Self administration order dated 9-15-23 and 11-4-24 for lubricating eye drops. -No order for earwax removal drops. Observation on 11-20-24 at 10:28 am of the medicine storage cabinet revealed: -A box labeled "Earwax Removal Drops" with a pharmacy label for Client #2. -Three boxes of name brand eye drops. Observation on 11-22-4 at 9:26 am of Client #1's medication revealed:	V 118		

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V 118	Continued From page 2 -No ear drops or ear wax removal medication. Observation on 11-22-24 at 9:29 am of Client #2's medication revealed: -Debrox 6.5%, Place 1 to 2 drops in each ear once a week for excessive cerumen, Dispensed 8-28-23. Review on 11-22-24 of a facility incident report dated 10-25-24 revealed: -Staff #1 went to give Client #1 a new bottle of eye drops. -Staff #1 gave Client #1 the earwax removal prescribed for Client #2. Interview on 11-20-24 with the day program staff revealed: -Client #1 would bring her eye drops with her to the day program. -Client #1 was complaining about her eyes bothering her. -Upon observation, Client #1 was self-administering another clients' ear drops into her eyes. -Client #1 had a physician's order for self-administration of eye drops. -The facility was contacted to make them aware of the error. Interview on 11-20-24 with the House Manager revealed: -Client #1 had eye drops that she can self-administer. -Client #1 would keep the eye drops with her and would ask staff when she needed a new bottle. -The night staff "...accidentally handed her a bottle of ear drops that belonged to another client." Interview on 11-25-24 with Staff #1 revealed:	V 118		

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V 118	Continued From page 3 -They eye drops for Client #1 were in a similar box to the ear drops for Client #2. -"It was a little confusing with all the medications in the drawer..." -"I know it was my error." -The medications have been rearranged and separated by the Team Lead. -Completed medication administration retraining a week after this incident. Interview on 11-22-24 with the Qualified Professional revealed: -Staff have been retrained in medication administration. -The medication drawers have been rearranged and medications have individual bags with additional labels to help prevent this situation from happening again. -Client #1 and Staff #1 were "running late" and staff have been retrained to "slow down." -"Double checking multiple times as well as separate bags will help a lot." -The local hospital did not do any treatment, but they recommended to reflush the eyes when back at the facility. -Staff #1 took steps to support Client #1 once the mistake had been discovered. Interviews on 11-20-24 and 11-26-24 with the Executive Director revealed: -"[Staff #1] grabbed the wrong bottle (of eye drops) to give to [Client #1] to take to work and didn't pay attention..." -"It was an error." -Staff #1 went back through medication administration training. -The local hospital did not flush Client #1's eyes, they just stated to monitor. -Worked with the House Manager about medication storage and labeling.	V 118		

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V 118	Continued From page 4 -Would also do more medication training with Client #1.	V 118		
V 367	27G .0604 Incident Reporting Requirements 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 (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	V 367		

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V 367	Continued From page 5	V 367		

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. The report shall be submitted on a form provided by the Secretary via electronic means and shall include summary information as follows:
(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

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V 367	Continued From page 6 (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 reviews and interviews, the facility failed to report level II incidents in the Incident Response Improvement System (IRIS) within 72 hours of becoming aware of the incident. The findings are: Review on 11-19-24 and 11-20-24 of IRIS revealed: -Incident occurred on 10-22-24 with Client #1. -Client #1 had a seizure and fell, requiring staples to her head by the local hospital emergency room. -Submission to IRIS was on 10-28-24. -No incident report dated 10-19-24. Review on 11-22-24 of Facility Incident Report dated 10-19-24 revealed: -Client #1 fell during a seizure. -Emergency Medical Services was called and transported Client #1 to the local hospital emergency room where she received stitches in her head. Review of email on 11-22-24 from the Executive Director (ED) revealed:	V 367		

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V 367	Continued From page 7 -Had received the report and responded immediately. -She was responsible for the late admission to IRIS. Interview on 11-22-24 with the Qualified Professional (QP) revealed: -Had only been the QP for this facility for about a month. -If outside of business hours, whoever responded to the incident (on call worker or the QP) would be responsible for submitting to IRIS. -Was not working or on call when the incident occurred. -The individual that submitted the incident into IRIS would also be responsible for following up. Interview on 11-26-24 with the ED revealed: -Was an oversight on her part. -The incident happened on the weekend and "...we didn't have internet at the office and my house." -"We dealt with the situation and handled it, but it was an oversight about IRIS." This deficiency constitutes a re-cited deficiency and must be corrected within 30 days.	V 367		