STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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	MHL040-007	B. WING		07/2	2/2025
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
DOGWOOD 212 DOGWOOD LANE					
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INITIAL COMMENTS		V 000			
This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disability.					
census of 3. The su	rvey sample consisted of				
27G .5603 Supervis	sed Living - Operations	V 291			
(a) Capacity. A face six clients when the developmental disal on June 15, 2001, a than six clients at the provide services at licensed capacity. (b) Service Coording maintained between qualified profession treatment/habilitation (c) Participation of Responsible Persor provided the opport relationship with helmeans as visits to the facility. Reports annually to the pare legally responsible progress toward medical progress toward progress toward medical progress toward medical progress toward progress toward medical progress toward medical progress toward progress towar	illity shall serve no more than clients have mental illness or bilities. Any facility licensed and providing services to more that time, may continue to no more than the facility's nation. Coordination shall be a the facility operator and the als who are responsible for an or case management. The Family or Legally note a client shall be unity to maintain an ongoing or or his family through such the facility and visits outside a shall be submitted at least ant of a minor resident, or the person of an adult resident. Writing or take the form of a setting individual goals.				
o	SUMMARY STA' (EACH DEFICIENCY REGULATORY OR LS  INITIAL COMMENT  An annual and follow on July 22, 2025. Definition of the second	MHL040-007  ROVIDER OR SUPPLIER  STREET AD  212 DOGN SNOW HII  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An annual and follow up survey was completed on July 22, 2025. 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 3 current clients.  27G .5603 Supervised Living - Operations  10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's	MHL040-007  ROVIDER OR SUPPLIER  STREET ADDRESS, CITY, S  212 DOGWOOD LANE SNOW HILL, NC 2858  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  An annual and follow up survey was completed on July 22, 2025. 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 3 current clients.  27G .5603 Supervised Living - Operations  10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients when the clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed capacity.  (b) Service Coordination. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatment/habilitation or case management.  (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible person of an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's program Activities. Each client shall have activity opportunities based on her/his choices,	MHL040-007    B. WING	MHL040-007  STREET ADDRESS. CITY. STATE, ZIP CODE  212 DOGWOOD LANE  SNOW HILL, NC 28580  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PLLI (EACH DEFICIENCY MUST BE PRECEDED BY PLLI REGULATORY OR LSC IDMITPING INFORMATION)  INITIAL COMMENTS  An annual and follow up survey was completed on July 22, 2025. Deficiencies were cited.  This facility is licensed for the following service category: 10 A 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 3 current clients.  27G .5603 Supervised Living - Operations  10A NCAC 27G .5603 OPERATIONS (a) Capacity. A facility shall serve no more than six clients have mental illness or developmental disabilities. Any facility licensed on June 15, 2001, and providing services to more than six clients at that time, may continue to provide services at no more than the facility's licensed conduction. Coordination shall be maintained between the facility operator and the qualified professionals who are responsible for treatmenthabilitation or case management. (c) Participation of the Family or Legally Responsible Person. Each client shall be provided the opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be submitted at least annually to the parent of a minor resident, or the legally responsible Person. Each client shall have activity opportunity to maintain an ongoing relationship with her or his family through such means as visits to the facility and visits outside the facility. Reports shall be on an adult resident. Reports may be in writing or take the form of a conference and shall focus on the client's progress toward meeting individual goals. (d) Program Activities. Each client shall have activity opportunities based on her/his choices,

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

(X6) DATE TITLE

NAME OF PROVIDER OR SUPPLIER  DOGWOOD  212 DOGWOOD LANE SNOW HILL, NC 28580  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  V 291  Continued From page 1  V 291  V 291  STREET ADDRESS, CITY, STATE, ZIP CODE (E12 DOGWOOD LANE SNOW HILL, NC 28580  ID PROVIDER'S PLAN OF CORRECTION PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  V 291	R 07/22/2025 (X5) COMPLETE DATE
DOGWOOD  212 DOGWOOD LANE SNOW HILL, NC 28580  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 291 Continued From page 1  V 291	COMPLETE
SNOW HILL, NC 28580  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 291 Continued From page 1  V 291	COMPLETE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  V 291 Continued From page 1  V 291  V 291	COMPLETE
Activities shall be designed to foster community inclusion. Choices may be limited when the court or legal system is involved or when health or safety issues become a primary concern.	
This Rule is not met as evidenced by: Based on record reviews, observation and interviews, the facility failed to maintain coordination between the facility operator and the professionals who are responsible for the client's treatment, affecting one of three audited clients (#2). The findings are:	
Review on 7/22/25 of client #2's record revealed:  - Date of admission: 2/16/16.  - Diagnoses of Autism, Agitation, Intellectual Developmental Disability, Bizarre Behavior, Seizures, Tremor, Prader Willi Syndrome - Physician's Visit Form dated 1/25/23- "Progress Notes/Findings: PT (Patient) has heavy build up. Will need to have deep cleaningBeing referred out for dental treatment." - A completed referral form with a partial "scanned 1/23 stamp on it "for client #2 to a hospital dental clinic in a neighboring city. "Please indicate the patients qualifying medical condition: Intellectual/Developmental Disabilities" - No documented follow up or appointments for dental treatment.	
Interview on 7/22/25 client #2 would not answer questions when asked.  Interview on 7/22/25 the Starter stated: - He worked 1:1 with client #2 and client #2 had	

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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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V 291	Continued From page 2		V 291			
	representative state - Client #2 needed his teeth and he wo office on 1/25/23 so - Client #2 had not last appointment or Interview on 7/22/2 stated: - He was not aware hospital dental clini - "The previous me handled the referra filled three times si - "He would inform	scaling and root planning for ould not allow treatment in the or he was referred out. been to the office since the office sin				
V 736	10A NCAC 27G .03 EXTERIOR REQU (c) Each facility and maintained in a saf manner and shall be odor.  This Rule is not man Based on observation was not maintained manner. The findir Observation on 7/2 11:37am revealed: - The kitchen cabin had no door.	d its grounds shall be te, clean, attractive and orderly be kept free from offensive et as evidenced by: ion and interviews the facility d in a safe, clean and attractive	V 736			

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STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		MHL040-007	D. WING		07/2	2/2025
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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V 736	and black colored, v - The freezer handle - Client #3 had a 9 of drawer was without 1 knob was without 1 knob An approximately above the fire exting linterview on 7/24/28 Professional stated - The kitchen cabine	various shapes spots on it. e was missing. drawer dresser- 1 right side 2 knobs, 1 right side drawer . The left side 2nd drawer s and the top left drawer was 3 inch hole in the hallway guisher. 5 the Director/Qualified :	V 736			

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Division of Health Service Regulation STATE FORM

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