STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 complaint survey was completed on August 26, 2026. The complaints were substantiated (intake #NC00232666 and intake #NC00232708). 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 1. The survey sample consisted of audits of 1 current client.	V 000		
V 291	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 progress toward meeting individual goals. (d) Program Activities. Each client shall have	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 291	Continued From page 1 activity opportunities based on her/his choices, needs and the treatment/habilitation plan. 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 and interviews, the facility failed to maintain coordination between the facility operator and the professionals responsible for the client's treatment affecting 1 of 2 Former Clients (FC #1). The findings are: Review on 8/22/25 of FC #1's record revealed: -An admission date of 6/18/21 -Diagnoses of Autism and Unspecified Intellectual Disability, Tuberous Sclerosis, Mixed Hyperlipidemia, Epilepsy -A discharge date of 7/11/25 -An assessment dated 6/18/21 noted "has a rare, multi-system genetic disorder in which benign tumors can grow on the brain or vital organs in which the central nervous system is affected which can result in seizures, developmental delays, behavior problems and skin abnormalities and kidney disease, requires support to manage Eczema and takes medication via injections, needs support to prevent him from chewing holes in his shirts and eating inedible times, needs help to prevent him from hitting or scratching himself and others when upset, needs additional support from a psychiatrist, has a history of self-injurious behaviors, property destruction and unsafe behavior in a vehicle, intentional and self-directed behavior that might result in tissue damage, typically strikes and/or bites himself, struggles	V 291		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 291	Continued From page 2	V 291		

with expressing his needs and wants, which poses a significant challenge for him, his inability to communicate effectively often leads to frustration, potentially influencing his behavior, requires 24 hour supervision due to wandering away while home and in the community, when he is upset, he may stomp his feet, attempt to hit and scratch himself and hit himself in the private areas."
-A treatment plan dated 1/1/25 noted "will maintain and increase existing community access and ability to independently increase his community connections, will attend his primary care physician wellness visits as well as age appropriate screenings, regular dental appointments and specialty appoints as needed, will comply with medication administrations and prn follow up, will attend the YMCA on a regular basis, will receive tailored plan care management services throughout the year to assist in coordinating service needs, will receive ongoing support and monitoring to ensure his health, safety and overall well-being, will received care management to assist in managing physical and behavioral health care needs, will assist with completing toileting skills by standing to remove soiled diaper per trial for 6 consecutive months, with assistance from staff, will dress appropriately for the weather, will complete daily bath/shower with staff assistance per trial, will brush his teeth with assistance from staff, will assist staff to comb his hair, will demonstrate safety in the community with no more than two verbal prompts, will apply deodorant with staff assistance, will make his bed with staff assistance, will independently practice safety from self-harm, will independently refrain from physical aggression daily for 6 consecutive months, will work on goals that focus on engaging in activities with his peers, will improve his safety awareness skills and will independently increase

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 291	Continued From page 3	V 291		

his opportunity for socialization while in the community."

Further review on 8/22/25 of FC #1's record revealed:
-No documentation the LG was notified of FC #1's self-injurious behaviors in July 2025 that resulted in a bruise to the neck.

Review on 8/22/25 of the North Carolina Incident Response Improvement System (IRIS) report dated 7/17/25 revealed:
-"[FC #1] had a history in his plan of SIB (Self Injurious Behaviors) including hitting himself in the head and neck area. He also has skin abnormalities in his plan."

Review on 8/22/25 of FC #1's after summary visit, dated 7/18/25 revealed:
-"Encounter diagnosis: Contusion of neck. Origin of contusion is unknown. No indication for imaging.
-Patient is a 24-year-old male who presents today with caregiver. History per caregiver. His caretaker states that she noticed a bruise on the patient's neck. It is believed the bruise has been present for 4 to 5 days. The patient is nonverbal. Mechanism of bruising is unknown."

Interview was not conducted with FC #1 as he was nonverbal and unable to communicate

Interview on 8/22/25 with FC #1's Legal Guardian (LG) revealed:
-Was not made aware FC #1 had a self-injurious behavior in July 2025 that resulted in a contusion to his neck.
-Took FC #1 to urgent care to have the contusion evaluated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 291	Continued From page 4 Interview on 8/22/25 with the Qualified Professional revealed: -FC #1 had self-injurious behaviors that led to a bruise on his neck sometimes in July 2025 -Had no documentation of how the injury occurred. -FC #1's LG took him to the doctor's office after noticing the bruise -Failed to notify the LG of the injury to FC #1's neck after a self-injurious behavior occurred.	V 291		
V 366	27G .0603 Incident Response Requirements 10A NCAC 27G .0603 INCIDENT RESPONSE REQUIREMENTS FOR CATEGORY A AND B PROVIDERS (a) Category A and B providers shall develop and implement written policies governing their response to level I, II or III incidents. The policies shall require the provider to respond by: (1) attending to the health and safety needs of individuals involved in the incident; (2) determining the cause of the incident; (3) developing and implementing corrective measures according to provider specified timeframes not to exceed 45 days; (4) developing and implementing measures to prevent similar incidents according to provider specified timeframes not to exceed 45 days; (5) assigning person(s) to be responsible for implementation of the corrections and preventive measures; (6) adhering to confidentiality requirements set forth in G.S. 75, Article 2A, 10A NCAC 26B, 42 CFR Parts 2 and 3 and 45 CFR Parts 160 and 164; and (7) maintaining documentation regarding Subparagraphs (a)(1) through (a)(6) of this Rule. (b) In addition to the requirements set forth in	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 366	Continued From page 5 Paragraph (a) of this Rule, ICF/MR providers shall address incidents as required by the federal regulations in 42 CFR Part 483 Subpart I. (c) In addition to the requirements set forth in Paragraph (a) of this Rule, Category A and B providers, excluding ICF/MR providers, shall develop and implement written policies governing their response to a level III incident that occurs while the provider is delivering a billable service or while the client is on the provider's premises. The policies shall require the provider to respond by: (1) immediately securing the client record by: (A) obtaining the client record; (B) making a photocopy; (C) certifying the copy's completeness; and (D) transferring the copy to an internal review team; (2) convening a meeting of an internal review team within 24 hours of the incident. The internal review team shall consist of individuals who were not involved in the incident and who were not responsible for the client's direct care or with direct professional oversight of the client's services at the time of the incident. The internal review team shall complete all of the activities as follows: (A) review the copy of the client record to determine the facts and causes of the incident and make recommendations for minimizing the occurrence of future incidents; (B) gather other information needed; (C) issue written preliminary findings of fact within five working days of the incident. The preliminary findings of fact shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different; and	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 366	Continued From page 6 (D) issue a final written report signed by the owner within three months of the incident. The final report shall be sent to the LME in whose catchment area the provider is located and to the LME where the client resides, if different. The final written report shall address the issues identified by the internal review team, shall include all public documents pertinent to the incident, and shall make recommendations for minimizing the occurrence of future incidents. If all documents needed for the report are not available within three months of the incident, the LME may give the provider an extension of up to three months to submit the final report; and (3) immediately notifying the following: (A) the LME responsible for the catchment area where the services are provided pursuant to Rule .0604; (B) the LME where the client resides, if different; (C) the provider agency with responsibility for maintaining and updating the client's treatment plan, if different from the reporting provider; (D) the Department; (E) the client's legal guardian, as applicable; and (F) any other authorities required by law. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to implement written policies governing their response to Level II incidents as required. The findings are:	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 366	Continued From page 7 Review on 8/22/25 of Former Client #1's record revealed: -An admission date of 6/18/21 -Diagnoses of Autism and Unspecified Intellectual Disability, Tuberous Sclerosis, Mixed Hyperlipidemia, Epilepsy -A discharge date of 7/11/25 Review on 8/22/25 of the North Carolina Incident Response Improvement System (IRIS) report dated 7/17/25 revealed: -"[FC #1] had a history in his plan of SIB (Self Injurious Behaviors) including hitting himself in the head and neck area. He also has a skin abnormalities in his plan." Review on 8/22/25 of FC #1's after summary visit, dated 7/18/25 revealed: -"Encounter diagnosis: Contusion of neck. Origin of contusion is unknown. No indication for imaging. -Patient is a 24-year-old male who presents today with caregiver. History per caregiver. His caretaker states that she noticed a bruise on the patient's neck. It is believed the bruise has been present for 4 to 5 days. The patient is nonverbal. Mechanism of bruising is unknown." Interview was not conducted with FC #1 as he was nonverbal and unable to communicate. Interview on 8/22/25 with the Qualified Professional revealed: -FC #1 had self-injurious behaviors that led to a bruise on his neck sometimes in July 2025 -Had no documentation of how the injury occurred. -FC #1's LG took him to the doctor's office after noticing the bruise	V 366		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL029-103	A. BUILDING: _____ B. WING _____	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DREAM MAKERS ASSISTED LIVING SERVICES, INC	168 ROY LOPP ROAD LEXINGTON, NC 27292

(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 366	Continued From page 8 -Failed to notify the LG of the injury to FC #1's neck after a self-injurious behavior occurred. -Did not have documentation regarding attending to the health and safety needs of Former Client #1 involved in the incident, determining the cause of the incident, developing and implementing correct measures, developing and implanting measures to prevent similar incidents, assigning a person to be responsible for the implementation of the corrections and preventative measures.	V 366		