

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/05/2025  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>34G185</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                               |                            | (X3) DATE SURVEY<br>COMPLETED<br><br><b>07/23/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DALMOOR DRIVE GROUP HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4400 DALMOOR DRIVE<br/>CHARLOTTE, NC 28212</b>                                                                                                                                                                                                                                                                                                                         |                            |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                            | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                           | (X5)<br>COMPLETION<br>DATE |                                                        |
| W 104                                                               | <p><b>GOVERNING BODY</b><br/>CFR(s): 483.410(a)(1)</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to report damaged equipment for repair. This effected 6 of 6 clients (#1, #2, #3, #4, #5, and #6). The finding is:</p> <p>Observations throughout the survey on 7/22/25-7/23/25 revealed all the facility's exterior door chimes were not in working condition.</p> <p>Review of clients' records on 7/22/25 for all clients(#1, #2,#3, #4, #5, and #6) revealed Behavior Support Plan Consents which indicated door chimes were used for safety.</p> <p>Interview on 7/23/25 with the qualified intellectual disabilities professional (QIDP) confirmed the door chimes had not been working and that they have been faulty due to wiring.</p> | W 104                                                                      | <p>W- 104</p> <p>Autism Services of Mecklenburg County will adhere to the standard policy and procedures to ensure prompt facility repairs and damaged equipments are repaired in a timely manner. The Program Coordinator and/ or QIDP will conduct weekly facility observations and promptly report any maintenance needs to the department supervisor.</p> <p>To be completed by QIDP by September 15, 2025</p> |                            |                                                        |
| W 249                                                               | <p><b>PROGRAM IMPLEMENTATION</b><br/>CFR(s): 483.440(d)(1)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>This STANDARD is not met as evidenced by:<br/>Based on observation, record review and</p>                                                                                                                                                                                                                                                                                                                                                                                                            | W 249                                                                      | <p>RECEIVED</p> <p>AUG 18 2025</p> <p>DHSR-MH Licensure Sect</p>                                                                                                                                                                                                                                                                                                                                                   |                            |                                                        |

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

TITLE

(X6) DATE

Executive Director/CEO

8/13/25

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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| NAME OF PROVIDER OR SUPPLIER<br><br><b>DALMOOR DRIVE GROUP HOME</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4400 DALMOOR DRIVE<br/>CHARLOTTE, NC 28212</b>                                                                                                                                                                                                                                                                                                                                                                                                                                             |                            |                                                        |
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| W 249                                                               | Continued From page 1<br>interview the facility failed to utilize the adaptive equipment that was implemented as an identified need in the individual support plan (ISP) for 1 of 6 clients (#6). The findings are:<br><br>Observation at the home on 7/23/25 from 5:55 AM-6:16 AM revealed client #6 was observed not wearing his knee pads. Further observation revealed client #6 to crawl on the floor on his knees around the dining room table for 21 minutes. Continued observation revealed at no point did staff intervene and client #6 was able to get off the floor on his own.<br><br>Review of the record on 7/23/25 for client #6 revealed an ISP dated 12/4/24 and a Behavior Support Plan consent dated 6/24/25 which identified the following adaptive equipment: gloves (severe SIB), kneepads and wheelchair for safety.<br><br>Interview on 7/23/25 with the qualified intellectual disabilities professional (QIDP) confirmed client #6 should have been wearing his kneepads during waking hours. Continued interview with the QIDP revealed staff should have intervened and assisted client #6's with putting on his kneepads. | W 249                                                                      | W-249<br><br>The QIDP will provide in-services/ formal training to staff to ensure that client # 6 adaptive equipment is being implemented as its identified in the individual support plan and the Behavioral Support Plan as an safety measure.<br>The Program Coordinator will conduct weekly observations in the group home to ensure that client is provided active treatment and utilize the adaptive equipment as written in the plan. QIDP will monitor at least monthly.<br><br>To be completed by QIDP by September 15, 2025 |                            |                                                        |
| W 340                                                               | NURSING SERVICES<br>CFR(s): 483.460(c)(5)(i)<br><br>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.<br>This STANDARD is not met as evidenced by:<br>Based on observation and interviews, the facility                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | W 340                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                            |                                                        |



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| W 340                                                               | <p>Continued From page 2</p> <p>failed to ensure staff were sufficiently trained to implement appropriate health and hygiene methods. This affected 1 of 6 clients in the home (#6). The findings are:</p> <p>Observation in the home on 7/23/25 at 7:28 AM revealed client #6 to enter the medication administration room and prepare for medication administration. Continued observations revealed staff A to obtain the medications from the cart, educate the client and punch medications into medicine cup. Further observations revealed staff A to drop two pills onto the floor, picked them up and placed them into the medicine cup along with the other medications.</p> <p>Subsequent observation revealed client #6 to take all medications with applesauce. Continued observation revealed at no point did staff A notify the facility nurse of the two pills she dropped nor did she discard them.</p> <p>Interview with the facility nurse on 7/23/25 revealed that it's the facility's policy for staff to call the nurse on duty after dropping a pill on the floor, the nurse will instruct the staff to discard the pill and give a new pill to the client. Further interview with the facility nurse confirmed that the staff should have followed the facility's medication administration policy.</p> | W 340                                                                      | <p>W -340</p> <p>The clinical team will in-service staff on appropriate health and hygiene methods on administer medications for client # 6. The clinical team will also conduct an in-service to staff on the policy and procedures of disposal of medication and reporting to the facility nurse.</p> <p>The Program Coordinator will conduct weekly observations in the group home to ensure that staff is following the facility's medication administration policy.QIDP will monitor at least monthly.</p> <p>To be completed by QIDP by September 15, 2025</p> |                            |                                                        |
| W 448                                                               | <p>EVACUATION DRILLS</p> <p>CFR(s): 483.470(i)(2)(iv)</p> <p>The facility must investigate all problems with evacuation drills, including accidents. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to investigate all problems with</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | W 448                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                            |                                                        |



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| W 448                                                               | Continued From page 3<br>evacuation drills specific to the timeliness of the<br>evacuation. The finding is:<br><br>Review of the facility fire drill reports on 7/22/25<br>revealed four fire drills that exceeded 3 minutes<br>of evacuation time: 8/24(10:50), 9/24(6:30),<br>11/24(5:40), and 2/25(6:00). Continued review of<br>the fire drills report revealed no evidence of a<br>review for times exceeding 3 minutes.<br><br>Interview with the qualified intellectual disabilities<br>professional (QIDP) revealed that the expectation<br>for the fire drill evacuation time is not to exceed 3<br>minutes. Continued interview with the QIDP<br>confirmed that the facility is responsible for<br>reviewing drills and ensuring timeliness of<br>evacuation and developing a plan to address any<br>difficulties with fire drills. | W 448                                                                      | W- 448<br><br>The Dalmoor Group Home will show<br>evidence on the quarterly fire drill<br>evacuation time. If the evacuation time<br>does exceed 3 minutes they will state why<br>and QIDP will develop a plan to address<br>any difficulties that arise. The Program<br>Coordinator/ QIDP will review monthly/<br>quarterly reports to ensure drills<br>evacuation time is within the timeline.<br><br>To be completed by QIDP by September<br>15, 2025 |                            |                                                        |
| W 485                                                               | DINING AREAS AND SERVICE<br>CFR(s): 483.480(d)(4)<br><br>The facility must supervise and staff dining rooms<br>adequately.<br>This STANDARD is not met as evidenced by:<br>Based on observation, record review and<br>interview, the facility failed to ensure sufficient<br>supervision in the dining room for 1 of 6 clients<br>(#1). The findings is:<br><br>Observations in the home on 7/23/25 revealed<br>client #1 to participate in the breakfast meal<br>which included ½ cup of juice, ¾ cup of oatmeal,<br>1 blueberry muffin, 1 tsp low fat margarine, ½ cup<br>of cinnamon applesauce, and milk/water/coffee.<br>Continued observation revealed client #1 sat at<br>the dining table eating his food at a fast paced<br>when staff prompted him to wait. Further<br>observation revealed staff walked out of the                 | W 485                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                            |                                                        |

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| W 485                                                               | <p>Continued From page 4</p> <p>dining room into the kitchen leaving client #1 at the table alone.</p> <p>Subsequent observation revealed client #1 to grab a blueberry muffin off another client's plate and stuffed it in his mouth. Continued observation revealed there were no additional staff in the dining area providing supervision.</p> <p>Review on 7/22/25 of client #1's Behavior Support Plan dated 12/5/24, identified the following target behaviors: agitation, pica, inappropriate toileting, food seeking (Gary has diabetes. He will raid the pantry getting into the snack bin. This typically happens at night.) and physical aggression.</p> <p>Review on 7/22/25 of client #1's Physician Orders dated 6/21/25 indicated a 3000 calorie, controlled CHO(Consistent Carbohydrate diet) with 3 meals and 3 snacks.</p> <p>Interview on 5/29/25 with the qualified intellectual disabilities professional (QIDP) revealed staff should provide supervision during all mealtimes.</p> | W 485                                                                      | <p>W- 485</p> <p>The clinical team will in-service staff on supervision during family style dining. Staff will also be in-service on client # 1 Behavioral Support Plan and dietary physician orders.</p> <p>The Program Coordinator will conduct weekly observations in the group home to ensure that staff is following the Behavioral Support Plan and Dietary Physician orders as written. QIDP will monitor at least monthly.</p> <p>To be completed by QIDP by September 15, 2025</p> |                            |                                                        |