Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL074-158	A. BUILDING: _____ B. WING _____	R 07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIMBLEDON SUPERVISED LIVING	1650 WIMBLEDON DRIVE #101 GREENVILLE, NC 27858

(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 follow up survey was completed on July 27, 2018. A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.	V 000	DHSR - Mental Health AUG 09 2018 Lic. & Cert. Section	
V 736	27G .0303(c) Facility and Grounds Maintenance 10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (c) Each facility and its grounds shall be maintained in a safe, clean, attractive and orderly manner and shall be kept free from offensive odor. This Rule is not met as evidenced by: Based on observation and interview the Licensee failed to maintain the facility in an attractive manner. The findings are: Observations on 7/26/18 between 9:30 am and 10:00 am revealed: - A hole in the wall at the front door. - The finish on the dining room table was scratched and worn. - Black scuff marks and scratches on the walls throughout the facility including the hallway and bedrooms. - A large hole at the bottom of Client #1's bedroom door. - A hole at the bottom of Client #1's closet door. - Black scuff marks at the bottom of Client #2's bedroom door. Interview on 7/26/18 the Program Manager stated the apartment complex management was slow	V 736	-Doors will be patched and/or replaced And plexiglass will be applied to prevent Future damage to the doors. -Dining room table will be replaced. -Touchup paint will be applied to the Walls and plexiglass will be upgraded To prevent further damage to the wall.	9/10/18 9/10/18

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Vicki Baldwin — TITLE: Program Manager — (X6) DATE: 8/7/18

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIMBLEDON SUPERVISED LIVING	1650 WIMBLEDON DRIVE #101 GREENVILLE, NC 27858

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V 736	Continued From page 1 about ensuring repairs were made as reported. She would follow up regarding the needed repairs.	V 736		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
MHL074-158 Y1	A. Building B. Wing Y2	7/27/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WIMBLEDON SUPERVISED LIVING	1650 WIMBLEDON DRIVE #101 GREENVILLE, NC 27858

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix V0118 Reg. # 27G .0209 (C) LSC	Correction Completed 07/27/2018	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR Connie Anderson	DATE 7/27/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE Facility Compliance Consultant I	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/9/2017		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		

EVENT ID: EZGW12

STATE FORM: REVISIT REPORT (11/06)

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

July 30, 2018

Heather Humphrey-Greer, Licensing & Regulatory Coordinator
Easter Seals UCP North Carolina & Virginia, Inc.
5171 Glenwood Avenue Suite 211
Raleigh, NC 27612

Re: Annual and Follow-Up Survey completed 7/27/18
Wimbledon Supervised Living, 1650 Wimbledon Drive #101, Greenville, NC
MHL # 074-158
E-mail Address: heather.humphrey-greer@eastersealsucp.com;
nikki.baker@eastersealsucp.com

Dear Ms. Humphrey-Greer:

Thank you for the cooperation and courtesy extended during the annual and foolow-up survey completed July 27, 2018.

As a result of the follow up survey, it was determined that all of the deficiencies are now in compliance, which is reflected on the enclosed Revisit Report. An additional deficiency was cited during the survey.

Enclosed you will find the deficiency cited listed on the Statement of Deficiencies Form. The purpose of the Statement of Deficiencies is to provide you with specific details of the practice that does not comply with state regulations. You must develop one Plan of Correction that addresses each deficiency listed on the State Form, and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiency found, the time frame for compliance plus what to include in the Plan of Correction.

Type of Deficiencies Found

- The tag cited is standard level deficiency.

Time Frames for Compliance

- Standard level deficiency must be ***corrected*** within 60 days from the exit of the survey, which is September 25, 2018.

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).
- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the State Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all violations have been corrected. If we can be of further assistance, please call Wendy Boone, South Coastal Team Leader, at 252-568-2744.

Sincerely,

Connie Anderson

Connie Anderson
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Cc: Leza Wainwright, Director, Trillium Health Resources LME/MCO
Kim Keehn, Quality Management Director, Trillium Health Resources LME/MCO
File