STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R <b>03/11/2021</b>	
		MHL054-180	B. WING		03/1	1/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAMILTO	HAMILTON 3101 HENRY BOULEVARD KINSTON, NC 28504					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
V 000	INITIAL COMMENT	S	V 000			
	on March 11, 2021. substantiated (Intak Deficiencies were c This facility is licens category: 10A NCA	,				
V 111	10A NCAC 27G .02 TREATMENT/HABI PLAN (a) An assessment client, according to the delivery of servi be limited to: (1) the client's pres (2) the client's need (3) a provisional or established diagnos of admission, excep detoxification or oth	ESHALL DESTRICT STATES AND ASSETTION OR SERVICE SHALL BE COMPLETED TO A SHALL	V 111			
	(4) a pertinent soci and (5) evaluations or a psychiatric, substar vocational, as appro (b) When services establishment and i treatment/habilitation	al, family, and medical history; assessments, such as ace abuse, medical, and opriate to the client's needs. are provided prior to the amplementation of the on or service plan, hereafter plan," strategies to address the problem shall be documented.				

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						R	
		MHL054-180	B. WING			1/2021	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
Ι ΗΔΜΙΙΤΌΝ			RY BOULEV , NC 28504	/ARD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
V 111	This Rule is not me Based on record re facility failed to com admission affecting	et as evidenced by: view and interviews, the uplete an assessment prior to one of two audited clients	V 111				
	-20 year old maleDiagnoses of Bi-Po Explosive Disorder, Hyperactivity Disord Disease, and Cons -No initial assessmi	of client #2's record revealed:  blar Disorder, Intermittent Autism, Attention Deficit der, Anxiety, Periodontal tipation. ent completed prior to client ne facility from a sister facility.					
	-He had resided at -He had no concerr Interview on 09/14/ -Client #2 had prev facilityClient #2 was adm 2021 due to the nev placement optionQualified Professioneed for an admiss transferring to a sis -He would make su	facility since 1/26/21. In swith new facility placement.  20 the Licensee stated: Itiously resided at a sister  Itited to the facility in January Iv facility presenting as a better  In all (QP) was unaware of the Ition assessment when Iter facility. Iter these procedures were					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDELAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COIVIE	LLILD
		MHL054-180	B. WING			₹  1/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
HAMILTO	ON.	3101 HEN	IRY BOULEV	/ARD		
HAMILI	JN	KINSTON	, NC 28504			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a saf	ity and Grounds Maintenance 303 LOCATION AND IREMENTS d its grounds shall be ie, clean, attractive and orderly be kept free from offensive	V 736			
	was not maintained and orderly manner and orderly manner of the servations on 3/10:00am revealed:  -The vacant bedrood and was laying on the two window be had several broken -A large patched arbroken bed and a had layer bedrood blinds and the close hinges and were lated. The bottom two drawere missing hand	ion and interview, the facility of in a safe, clean, attractive or. The findings are:  10/21 at approximately  om had a broken bed frame the floor of the room. In the vacant bedroom a slates in the blinds. The interval behind the mole next to the window in the et doors were not attached to ying against the wall. awers of client #2's night stand les. right of the kitchen sink was				
	Operations reveale -The individual respanses already started repairs	d: on 3/11/21 the Director of d: onsible for maintenance had airs on facility concerns. maintenance concerns were				

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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	
				R		
		MHL054-180	B. WING		03/1	1/2021
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY, S	STATE, ZIP CODE		
HAMILTON			RY BOULEV , NC 28504	/ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 3	V 736			
V 738	<b>EXTERIOR REQUI</b>	03 LOCATION AND	V 738			
	failed to keep the failed to keep the failed to keep the failed are:  Observation on 3/1/10:00am revealed: -A dead insect was the dining roomThere was one emfloor at the end of the failed are:	et as evidenced by: on and interviews the facility acility free of insects. The  0/21 at approximately observed in an insect trap in apty insect trap located in the he hallway and one empty in the floor at the end of the				
	couple of daysAlthough he was u he had observed in Interview on 3/11/2 -He had been with o yearsHe had observed in periodically.	employed with facility for a ncertain as to what they were,				

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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	
			7t. Boilebiito.		F	2
		MHL054-180	B. WING		03/1	1/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
HAMILTO	ON		RY BOULEV , NC 28504	/ARD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
V 738	Continued From pa	ge 4	V 738			
	Prior to the last sev any mice for approx	en days, he had not observed kimately 1 month.				
	Interview on 3/10/2 -He had observed i -He had observed r	nsects in the facility.				
	Interview on 3/10/21 client #2 stated: -He had observed cockroaches and would "smash them" when finding them in the bathroomHe had seen "4 of them the other day."					
	stated: -The facility had an a quarterly basisHe was unaware of continued to have a keep the facility free	to monitor to keep the facility				

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