Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: MHL054-180 B. WING 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3101 HENRY BOULEVARD **HAMILTON** KINSTON, NC 28504 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 000 V 000 INITIAL COMMENTS A complaint and follow up survey was completed on March 11, 2021. The complaint was substantiated (Intake #NC00174972). Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities. V111 V 111 V 111 27G .0205 (A-B) Assessment/Treatment/Habilitation Plan Ambleside's policy did not reflect the requirement for an admission 10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE assessment to be completed when PLAN an individual relocates from one (a) An assessment shall be completed for a house to another home within the client, according to governing body policy, prior to the delivery of services, and shall include, but not Ambleside, Inc. program. be limited to: Ambleside's policy #2.1.10 -(1) the client's presenting problem; (2) the client's needs and strengths; Admissions Assessment will be (3) a provisional or admitting diagnosis with an updated to reflect this requirement. established diagnosis determined within 30 days of admission, except that a client admitted to a Furthermore, to ensure all Service detoxification or other 24-hour medical program Coordinators/QPs are aware of shall have an established diagnosis upon this requirement, a memo will be admission: (4) a pertinent social, family, and medical history; published by the Director of and Operations and signed by the (5) evaluations or assessments, such as psychiatric, substance abuse, medical, and Service Coordinators/QPs to vocational, as appropriate to the client's needs. reflect acknowledgment and (b) When services are provided prior to the establishment and implementation of the understanding of this policy update. treatment/habilitation or service plan, hereafter The signed memo will be placed in referred to as the "plan," strategies to address the client's presenting problem shall be documented. the SC/QPs personnel file, and will be verified by the Director of Operations Division of Health Service Regulation

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

9 03RC11

3.22.2021

DHSR - Mental Health

If continuation sheet 1 of 5

- - 0 0004

PRINTED: 03/15/2021 FORM APPROVED Division of Health Service Regulation STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ MHL054-180 B. WING \_ 03/11/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3101 HENRY BOULEVARD **HAMILTON** KINSTON, NC 28504 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) V 111 V 111 Continued From page 1 This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to complete an assessment prior to admission affecting one of two audited clients (#2). The findings are: Review on 3/10/21 of client #2's record revealed: -20 year old male. -Diagnoses of Bi-Polar Disorder, Intermittent Explosive Disorder, Autism, Attention Deficit Hyperactivity Disorder, Anxiety, Periodontal Disease, and Constipation. -No initial assessment completed prior to client #2's admission to the facility from a sister facility. Interview on 3/10/21 client #2 stated: -He had resided at facility since 1/26/21. -He had no concerns with new facility placement. Interview on 09/14/20 the Licensee stated: -Client #2 had previously resided at a sister facility. -Client #2 was admitted to the facility in January 2021 due to the new facility presenting as a better

Division of Health Service Regulation

placement option.

transferring to a sister facility.

sister facility to another.

-Qualified Professional (QP) was unaware of the need for an admission assessment when

-He would make sure these procedures were followed for any future clients moved from one

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED			
MILI 054 190		B. WING		R				
MHL054-180				03/	03/11/2021			
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
HAMILTO	HAMILTON 3101 HENRY BOULEVARD KINSTON, NC 28504							
(VA) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		T		(ME)		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
V 736	10A NCAC 27G .03 EXTERIOR REQUI (c) Each facility and maintained in a safe manner and shall be odor.  This Rule is not me Based on observations was not maintained and orderly manner.  Observations on 3/1 10:00am revealed:  -The vacant bedroom and was laying on the two window blines had several broken and several broken and a howall.  -Client #1's bedroom	its grounds shall be e, clean, attractive and orderly e kept free from offensive  et as evidenced by: on and interview, the facility in a safe, clean, attractive . The findings are:  10/21 at approximately m had a broken bed frame ne floor of the room. nds in the vacant bedroom slates in the blinds. ea in the wall behind the ole next to the window in the	V 736	V736 All maintenance and repair is will be completed by the Ambleside, Inc. Maintenance Supervisor. The Director of Operations will verify that all have been repaired, and all deficiencies addressed.	Э	3/30/21		
	hinges and were lay -The bottom two dra were missing handle	wers of client #2's night stand						
	During interview on a Operations revealed -The individual responsalready started reparations.	3/11/21 the Director of l: onsible for maintenance had irs on facility concerns.						
	-He would ensure m	aintenance concerns were						

O3RC11

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		ILTIPLE CONSTRUCTION DING:		(X3) DATE SURVEY COMPLETED			
					R				
MHL054-180			B. WING	B. WING 03.					
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
HAMILTON 3101 HENRY BOULEVARD KINSTON, NC 28504									
(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 736	Continued From page 3		V 736						
	completed.								
V 738	27G .0303(d) Pest Control  10A NCAC 27G .0303 LOCATION AND EXTERIOR REQUIREMENTS (d) Buildings shall be kept free from insects and rodents.		V 738	V738 Ambleside contracts Terminix for all pest control needs. Terminix will be contacted and informed of					
				the reported pest issues tak	-				
				place at this home, and will to address the matter. All ol	be asked	14			
				traps that have dead insects	will be	130/2			
	This Rule is not met as evidenced by: Based on observation and interviews the facility failed to keep the facility free of insects. The findings are:  Observation on 3/10/21 at approximately 10:00am revealed: -A dead insect was observed in an insect trap in the dining room.			replaced. The Director of Operations will contact Terminix for follow-up regarding bugs and potential rodents, and the Service Coordinat QP of Hamilton will contact the state		3/30/21			
						f			
floor at the end of the hallway and one empty		to have all traps replaced, a ensure that they have been.							
	couple of days.	employed with facility for a incertain as to what they were,							
	<ul><li>-He had been with years.</li><li>-He had observed i periodically.</li></ul>	1 Group Home Leader stated: company for approximately 2 nsects in the facility a mouse within the last 7 days.							
	-i le flau observeu e	a mouse within the last I days.							

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		
			A. BUILDING:			A SECTION AND A SECTION ASSESSMENT OF CO.		
MHL054-180		B. WING _	B. WING			R <b>03/11/2021</b>		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE				
HAMILT	HAMILTON 3101 HENRY BOULEVARD							
- AV 0. IB	CUBBBAADVOTA		, 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD B THE APPROPRI	BE ATE	(X5) COMPLETE DATE	
V 738	Continued From page	ge 4	V 738					
	Prior to the last seve any mice for approx	en days, he had not observed imately 1 month.						
	Interview on 3/10/21 -He had observed in -He had observed m	sects in the facility.						
	"smash them" when bathroom.	ockroaches and would finding them in the						
	-He had seen "4 of t	hem the other day."						
	stated: -The facility had an e	the Director of Operations exterminator that came out on						
	continued to have ar keep the facility free	o monitor to keep the facility					eri	
vision of Hor	alth Service Regulation							