Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	E, ZIP CODE		
			A. BOILDING.			
		MHL041-771	B. WING		03/0	7/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HAMPTON	N GROUP HOME		NTON COURT ORO, NC 2740	7		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID		N	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE DATE
V 000	INITIAL COMMENTS		V 000			
	An annual survey was 2024. Deficiencies we	s completed on March 7, ere cited.				
	category: 10A NCAC	d for the following service 27G .5600C Supervised Developmental Disability.				
	The facility is licensed for 6 and currently has a census of 6. The survey sample consisted of audits of 3 current clients.					
V 112	27G .0205 (C-D) Assessment/Treatme	nt/Habilitation Plan	V 112			
	10A NCAC 27G .0205 ASSESSMENT AND TREATMENT/HABILITATION OR SERVICE PLAN					
	(c) The plan shall be developed based on the assessment, and in partnership with the client or legally responsible person or both, within 30 days					
	of admission for clients who are expected to receive services beyond 30 days.  (d) The plan shall include:					
	(1) client outcome(s) that are anticipated to be achieved by provision of the service and a projected date of achievement;					
	(2) strategies;					
	annually in consultati	view of the plan at least on with the client or legally				
	responsible person o (5) basis for evaluat outcome achievemen	ion or assessment of t; and				
	(6) written consent or agreement by the client or responsible party, or a written statement by the provider stating why such consent could not be					
	obtained.					

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
		MHL041-771	B. WING		03/07/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STA	TE, ZIP CODE	
HAMPTO	GROUP HOME		RNTON COURT	-	
	OLUMBA DV OT		BORO, NC 2740		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
V 112	Continued From page	e 1	V 112		
	failed to develop and strategies for 2 of 3 c and failed to update t client or legally responsive clients (Clients #1, #2). Review on 3/6/24 of C-Admission date of 2/-Diagnoses of Severe Disability (IDD), Toure Disorder.  -No documentation of in consultation with Coperson.  Review on 3/6/24 of C-Admission date of 3/	ew and interview, the facility implement treatment lients (Clients #2 and #3) reatment plans with the nsible person for 3 of 3 and #3).  Client #1's record revealed: 14/06. Intellectual Developmental ette's Disorder, and Anxiety fan updated treatment plan lient #1's legally responsible  Client #2's record revealed: 1/19.			
		d Anxiety Disorder, Diabetes			
	Mellitus, Hypertension	n and Hyperlipemia. f an updated treatment plan			
	in consultation with C				
	-No documented trea	tment strategies.			
	Review on 3/6/24 with revealed: -Admission date of 7/ -Diagnoses of IDD, U Episodic Mood Disord	7/14. ncontrolled Type I Diabetes,			
		ral Hearing Loss-both ears,			

Division of Health Service Regulation

STATE FORM 90G011 If continuation sheet 2 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		MHL041-771	B. WING		03/07/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HAMPTON	LODOUBLIONE	115 THOR	NTON COURT			
HAMPIO	N GROUP HOME	GREENSB	ORO, NC 2740	7		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLET	E
V 112	Continued From page	2	V 112			
V 112	and Glaucoma.  -No documentation of in consultation with C persons.  -No documented treat Interview on 3/6/24 w.  -He was non-verbal at "yeah" when asked qualification.	f an updated treatment plan lient #3's legally responsible tment strategies.  ith Client #1 revealed: and responded only with uestions.  ith Client #2 revealed: and a goal he had. and ed Professional thim with tasks that	V 112			
	-He was not sure what his laundry.  Interviews on 3/6/24 at Licensee/QP revealed -She had not updated treatment plans with a responsible personShe understood how	at his goals were; he does and 3/7/24 with the d: d: Clients #1, #2 and #3's each client or their legally to update client treatment to help the clients achieve				
V 118	only be administered	9 MEDICATION	V 118			

Division of Health Service Regulation

STATE FORM 90G011 If continuation sheet 3 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
		MHL041-771	B. WING	B. WING		07/2024
	ROVIDER OR SUPPLIER	115 THOF	DRESS, CITY, STARNTON COURT BORO, NC 2740			
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
V 118	clients only when auticlient's physician.  (3) Medications, incluadministered only by unlicensed persons to pharmacist or other leprivileged to prepare  (4) A Medication Admall drugs administered current. Medications arecorded immediately MAR is to include the (A) client's name;  (B) name, strength, and (C) instructions for according to the control of the control	be self-administered by horized in writing by the ding injections, shall be licensed persons, or by rained by a registered nurse, egally qualified person and and administer medications. Inistration Record (MAR) of d to each client must be kept administered shall be after administration. The following:	V 118			
	authorized by law to p keep current the clien clients (Client #1). Th	ew, observation and failed to administer tten order of a person prescribe drugs and failed to at MAR affecting 1 of 3				

Division of Health Service Regulation

STATE FORM 90G011 If continuation sheet 4 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		MHL041-771	B. WING		03/07	7/2024
HAMPTON GROUP HOME 115 THORN			RESS, CITY, STANTON COURTORO, NC 2740			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
V 118	Disability (IDD), Toured Disorder.  -No physician order for (rash).  -No physician order for antifungal spray (rash).  Review on 3/7/24 of Control December 1, 2023 the revealed:  -Clotrimazole 1% Creduring this timeframe 8 am and 8 pm dosage administered by the Lorent Professional (Licensed -The OTC antifungal signal MAR during this timeform on 3/6/24 medications revealed -No Clotrimazole 1% facility.  Interview on 3/6/24 wording the Control of the Clotrimazole Crefacility in or about Octorshe was using the Obut there was no present antifunction of the Control of the Co	and the steel of t	V 118			

Division of Health Service Regulation

STATE FORM 90G011 If continuation sheet 5 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	A. BUILDING:		COMPLETED	
		MHL041-771	B. WING		03/0	7/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	TE ZIP CODE	1 55.5	
NAME OF T	NOVIDER OR GOLF EIER		RNTON COURT	WE, ZII GOBE		
HAMPTO	N GROUP HOME		SBORO, NC 2740	17		
040.15	CLIMMADY CT				ONI	0/5
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES.	PRIATE	DATE
				DEFICIENCY)		
V 750	Continued From page	e 5	V 750			
V 750	27G .0304(b)(3) Mair	ntenance of Elec., Mech., &	V 750			
	Water Systems	iteriarios er Lices, meeris, a				
		4 FACILITY DESIGN AND				
	EQUIPMENT	lity shall be designed,				
		pped in a manner that				
	•	safety of clients, staff and				
	visitors.	,				
	'	nechanical and water				
	systems shall be mai	ntained in operating				
	condition.					
	This Rule is not met	as evidenced by:				
		n and interview, the facility				
		toilet in operating condition.				
	The findings are:					
	Observation on 3/7/2	4 between 11:36 am-12:15				
	pm of the facility reve					
	-A toilet plunger insid					
	Intension on 2/7/04 ···	with the Licenses/Out-life-d				
	Professional revealed	rith the Licensee/Qualified				
		clogged and water was				
	draining slowly.					
		t stopped the toilet with a				
	toothpaste container.					
		t time the clients' toilet had				
	been clogged.					
		mber and was waiting for a				
	piumber to call back t	to set up a service call.				
	Interviews on 3/6/24 v	with Clients #2 and #3				
	revealed:					
	-They did not disclose	e any problems or issues				
	with the toilet.					

Division of Health Service Regulation

STATE FORM 90G011 If continuation sheet 6 of 7

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		E SURVEY PLETED
		MHL041-771	B. WING	<del></del>	0;	3/07/2024
NAME OF PE	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZIP CODE	•	
			RNTON COURT	12, 211 0002		
HAMPTON	GROUP HOME		BORO, NC 2740	7		
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE

Division of Health Service Regulation

STATE FORM 90G011 If continuation sheet 7 of 7