STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. Boilding.			
		mhl082-042	B. WING	WING R 05/30/20		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDOC	N CDOUD HOME	300 JACC	BS STREET			
SAMPSC	ON GROUP HOME	CLINTON	NC 28328			
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)		COMPLETE DATE
V 000	INITIAL COMMENT	-s	V 000			
		w up survey was completed reficiencies were cited.				
	category: 10A NCA	sed for the following service C 27G .5600C Supervised h Developmental Disabilities.				
	This facility is licensed for 5 and currently has a census of 4. The survey sample consisted of audits of 3 current clients.					
V 133	G.S. 122C-80 Crim	inal History Record Check	V 133			
	CHECK REQUIRED APPLICANTS FOR (a) Definition As a "provider" applies to program and any prodevelopmental disa services that is licer					
	provider licensed un applicant to fill a po applicant to have an	An offer of employment by a nder this Chapter to an sition that does not require the noccupational license is				
	criminal history reco the applicant has be less than five years	sent to a State and national ord check of the applicant. If een a resident of this State for , then the offer of employment				
	criminal history reconnational criminal his	onsent to a State and national ord check of the applicant. The story record check shall he applicant's fingerprints. If				
	the applicant has be five years or more,	een a resident of this State for then the offer is conditioned				
	check of the applica	te criminal history record ant. A provider shall not t who refuses to consent to a				

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

TITLE (X6) DATE

PRINTED: 06/03/2025 FORM APPROVED

Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		mhl082-042	B. WING		05/3	R 60/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDESS CITY S	STATE, ZIP CODE	•	
IVAIVIL OI I	NOVIDEN ON OUT FIELD		BS STREET			
SAMPSON GROUP HOME		NC 28328				
(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)	.D BE	(X5) COMPLETE DATE
V 133	criminal history recesection. Except as a subsection, within fithe conditional offer shall submit a requestive under G.S. criminal history recesection or shall submit to conduct a scheck required by the G.S. 114-19.10, the return the results of record checks for ecovered by Public L. Department of Hea Criminal Records C. Department of Hea Criminal Records C. Dusiness days of rehistory of the perso and Human Service Unit, shall notify the information receive of the applicant. In national criminal his with the provider. Pupon request verific check has been corby this section. A coappropriate local or the Division of Crimmay conduct on be criminal history recesection without the request to the Department of All criminal history is conditional offer of All criminal history is	ord check required by this otherwise provided in this ive business days of making of employment, a provider est to the Department of 114-19.10 to conduct a ord check required by this mit a request to a private State criminal history record his section. Notwithstanding Department of Justice shall in ational criminal history mployment positions not aw 105-277 to the lith and Human Services, check Unit. Within five deceipt of the national criminal in, the Department of Health es, Criminal Records Check in provider as to whether the did may affect the employability no case shall the results of the story record check be shared roviders shall make available cation that a criminal history impleted on any staff covered ounty that has adopted an dinance and has access to be in all Information data bank half of a provider a State ord check required by this provider having to submit a cartment of Justice. In such a call commence with the State ord check required by this pusiness days of the employment by the provider. Information received by the	V 133			
	section within five business days of the conditional offer of employment by the provider.  All criminal history information received by the provider is confidential and may not be disclosed,					

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
71101 1711	OF CONTROL	IDENTIFICATION NOWIBER.	A. BUILDING:	<del></del>	33 22.23	
		mhl082-042	B. WING		05/3	? 0/2025
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		300 JACO	BS STREET			
SAMPSO	ON GROUP HOME		NC 28328			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE	
V 133	Continued From pa	ige 2	V 133			
V 133	except to the application of the provider may disclot the provider disqualification of the criminal history to the disqualification of the criminal history to the disqualification of the criminal history to the disqualification (d) Limited Immunit	cant as provided in subsection For purposes of this m "private entity" means a engaged in conducting ord checks utilizing public om a State agency. oplicant's criminal history als one or more convictions of the provider shall consider all tors in determining whether to eriousness of the crime. crime. person at the time of the ces surrounding the crime, if known. veen the criminal conduct of job duties of the position to be probation, parole, employment records of the ate the crime was committed. t commission by the person of on of a relevant offense alone of employment; however, the be considered by the provider. ualifies an applicant after e relevant factors, then the ose information contained in record check that is relevant on, but may not provide a copy ory record check to the  ty A provider and an officer	V 133			
		rovider that, in good faith, section shall be immune from				

Division of Health Service Regulation STATE FORM

6899 I5FG11 If continuation sheet 3 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		B. WING		F		
		mhl082-042	B. WING		05/3	0/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAMPSO	N GROUP HOME		BS STREET			
CLINTON,		NC 28328				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
V 133	individual on the bathe criminal history (2) Failure to check criminal offenses if history record chec compliance with thi (e) Relevant Offense relevant offense federal criminal hist indictment of a criminal history persons needing middle have responsibility persons needing m	e provider to employ an sis of information provided in record check of the individual. an employee's history of the employee's criminal k is requested and received in	V 133			

Division of Health Service Regulation STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE S				
					F	.
		mhl082-042	B. WING			0/2025
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SAMPSON GROUP HOME		BS STREET , NC 28328	•			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	Protection of the Fa Intoxication; and Art Crime. These crime sale of drugs in viol Controlled Substance 90 of the General Soffenses such as a violation of G.S. 181 impaired in violation G.S. 20-138.5. (f) Penalty for Furni applicant for employ supplies, or otherwi an employment approximinal history reconshall be guilty of a C (g) Conditional Empemploy an applicant obtaining the results check regarding the following requireme (1) The provider shapior to obtaining the criminal history reconsubsection (b) of the fingerprint cards as (2) The provider shapior to obtain the criminal history reconsults as (2) The provider shapions as (2) The provider shapions as (3) The provider shapions as (4) The provider shapions as (5) The provider shapions as (6) The provider shapions as (7) The provider shapions as (8) The provider shapions as (9) The provider shapions as (1) The provider shapions as (1) The provider shapions as (1) The provider shapions as (2) The provider shapions (3) The provi	on of Minors; Article 40, amily; Article 59, Public ticle 60, Computer-Related as also include possession or ation of the North Carolina ces Act, Article 5 of Chapter statutes, and alcohol-related ale to underage persons in B-302 or driving while of G.S. 20-138.1 through shing False Information Any yment who willfully furnishes, se gives false information on olication that is the basis for a pord check under this section class A1 misdemeanor. Ployment A provider may to conditionally prior to so of a criminal history record applicant if both of the	V 133			
	This Rule is not me	et as evidenced by:				

Division of Health Service Regulation STATE FORM

lf continuation sheet 5 of 8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	mhl082-042		B. WING		05/3	R 0/2025
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	0/2020
SAMPSO	SAMPSON GROUP HOME 300 JACO CLINTON					
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
V 133	Based on record refacility failed to ensigned to ensigned the condition of	views and interviews, the ure the criminal history record ed within five business days of onal offer of employment ited staff (#1 and #2). The of staff #1's record revealed:  a criminal background check disince re-hire.  of staff #2's record revealed:  a criminal background check disince re-hire.  a criminal background check disince re-hire.  staff #2's record revealed:  a criminal background check disince re-hire.  25 staff #1 stated:  in February 2023.  by worked at the facility.  25 staff #2 stated:  at the facility for approximately  25 the Executive Director  at locate the criminal is.  bund checks were provided for	V 133			
V 736	10A NCAC 27G .03 EXTERIOR REQUI	ty and Grounds Maintenance 303 LOCATION AND IREMENTS I its grounds shall be	V 736			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE S COMPL			E SURVEY PLETED	
		mhl082-042	B. WING			R <b>30/2025</b>
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	TATE, ZIP CODE		
SAMPSO	ON GROUP HOME		BS STREET NC 28328			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
V 736	maintained in a safe manner and shall be odor.  This Rule is not me Based on observation was not maintained orderly manner. The Observation on 05/3:00pm revealed: The door bell on the control of the living room cand soiled spots on surface had ridges carpet separated. The sectional sofal layer of fabric peeled. The sectional sofal layer of fabric peeled. Client #4's bedroom scattered on the sum were 4 ping pong surface. Client #2's bedroom slats. The carpet in sized bits of debris. The vacant bedroom sized beloom the was spattered on the was spattered on the was spattered on the was spattered on the was of window blind had 2. Client #1's bedroom window blind. The courface.	e, clean, attractive and orderly e kept free from offensive  et as evidenced by: on and interview, the facility in a clean, attractive and e findings are:  29/25 at approximately the front door was cracked. The carpet had various sized black the carpet. The carpet in various spots where the a in the living room had the toped away in various spots. In had white bits of debris rface of his carpet. There ized dark spots on his carpet the window blind his bedroom had various on the surface. If the dresser drawer. The bent slats. In had 16 bent slats in his carpet had bits of debris on the	V 736			
	window blind had 2 - Client #1's bedrood window blind. The consurface Client #3's bedrood black spots on the consurface The hallway carped bedroom had black The left bathroom	bent slats. Im had 16 bent slats in his carpet had bits of debris on the lim had 3 soccer ball sized				

Division of Health Service Regulation

STATE FORM 6899 I5FG11 If continuation sheet 7 of 8

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPL			SURVEY PLETED	
		mhl082-042	B. WING	B. WING		R 30/2025
NAME OF	PROVIDER OR SUPPLIER		ODRESS, CITY, S	STATE, ZIP CODE		
SAMPSO	ON GROUP HOME		N, NC 28328			
(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 ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
V 736	Continued From pa	ge 7	V 736			
	stated: - The owner of the notified of issues ar - She would follow the state of th	facility building had been and estimates for carpet. up on identified issues. It cited 4 times since the 7/19 and must be corrected				

6899

Division of Health Service Regulation STATE FORM