

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL040005	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/06/2025
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NAME OF PROVIDER OR SUPPLIER AMBLESIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 1 INDUSTRIAL DRIVE SNOW HILL, NC 28580
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(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	<p>INITIAL COMMENTS</p> <p>A complaint survey was completed on November 6, 2025. The complaint was unsubstantiated (intake #NC00234271). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .2300 Adult Developmental Vocational Programs for Individuals with Developmental Disability, 10A NCAC 27G .5400 Day Actviity for Individuals of all Disability Groups and 10A NCAC 27G .5500 Sheltered Workshops for Individuals of All Disability Groups.</p> <p>This facility is licensed for 0 and has a current census of 31. The .2300 Adult Developmental Vocational Programs for Individuals with Developmental Disability has a current census of 31 and the .5400 Day Actviity for Individuals of all Disability Groups has a current census of 0 and the .5500 Sheltered Workshops for Individuals of All Disability Groups has a current census of 0. The survey sample consisted of audits of 3 current Adult Developmental Vocational Program for Individuals with Developmental Disability.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____