Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	MHL034-219		**04/06/2018**

NAME OF PROVIDER OR SUPPLIER

INSPIRATIONZ

STREET ADDRESS, CITY, STATE, ZIP CODE

607 HILLHAVEN DRIVE
WINSTON-SALEM, NC 27107

(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	INITIAL COMMENTS A complaint survey was completed on 4/6/18. The complaint was unsubstantiated . (Intake ID # NC000136480). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .1700, Residential Treatment Staff Secure for Children or Adolescents.	V 000		

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