STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL014-006	A. BUILDING: _____ B. WING _____	R 03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BURKWELL	3476 MORGANTON BOULEVARD LENOIR, NC 28645

(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 Limited follow up survey for the Type B was completed on 3/29/18. This was a limited follow up survey, only 10A NCAC 27G .0209 Medication Requirements (V118); 10A NCAC 27G .1701 Scope (V293); 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109); 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0209 Medication Requirements (V118); 10A NCAC 27G .1701 Scope (V293); 10A NCAC 27G .0203 Competencies of Qualified Professionals and Associate Professionals (V109); 10A NCAC 27G .0204 Competencies and Supervision of Paraprofessionals (V110). 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		