Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL040005	A. BUILDING: _____ B. WING _____	R 05/18/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBLESIDE	**1 INDUSTRIAL DRIVE SNOW HILL, NC 28580**

(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 and follow up survey was completed May 18, 2018. The complaints were unsubstantiated (Intake #NC 00138823.) No deficiencies were cited. This facility is licensed for the following service categories: 10A NCAC 27G .2300, Adult Developmental and Vocational Programs for Individuals with Developmental Disabilities; 10A NCAC 27G .5400, Day Activity for Individuals of All Disability Groups; and 10A NCAC 27G .5500, Sheltered Workshops for Individuals of All Disability Groups.	V 000		

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