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 |
|---|---|---|---|
| | MHL036-315 | A. BUILDING: ______ B. WING ______ | 06/29/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| SHEILA'S MAGNOLIA PLACE | 1619 FAIRFIELD DRIVE GASTONIA, NC 28054 |

| (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<br><br>An annual survey was attempted on 6/29/18. Director revealed no clients were being served at the facility at this time and the last client served was in 5/2018.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5100 Community Respite Services.<br><br>Observation on 6/29/18 at approximately 1:30pm of the facility revealed no clients on site.<br><br>Interview on 6/29/18 with the Director revealed:<br>-No clients being served at the facility at this time;<br>-Last respite service provided at the facility were on 5/4-7/18;<br>-The agency was considering two options for the facility: Open a group home for an MCO at this location or move one of their current homes to this location;<br>-She would informed the state upon the final decision. | V 000 | | |

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