

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/05/2018
NAME OF PROVIDER OR SUPPLIER MERCY CARE II		STREET ADDRESS, CITY, STATE, ZIP CODE 3950 ROSEBORO HIGHWAY CLINTON, NC 28328		
(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>An annual and follow-up survey was attempted on September 5, 2018. According to the Administrative Assistant there are no clients being served at the facility. The last time clients were served at the facility was before May 24, 2018.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>Interview on 09/05/18 the Administrative Assistant stated:</p> <ul style="list-style-type: none"> - The Licensee reported the last time a client was at the facility was before 05/24/18. - The agency was actively seeking admissions to the facility. - She was aware to notify the Division of Health Service Regulation when clients were admitted. 	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE