

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL005-021	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 09/13/2018
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NAME OF PROVIDER OR SUPPLIER HENSLEY HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 306 LOCUST STREET WEST JEFFERSON, NC 28694
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(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>A limited follow up survey for the Type A1 was completed on September 13, 2018. This was a limited follow up survey, only 10A NCAC 27G (b) .5603 Supervised Living - Operations (V291) with Cross Reference: 10A NCAC 27G .0202 (g) (3) Personnel Requirements (V108) and Cross Reference: 10A NCAC 27G .0209 (c) (1) (4) Medication Requirements (V118). The following were brought back into compliance: 10A NCAC 27G (b) .5603 Supervised Living - Operations (V291) with Cross Reference: 10A NCAC 27G .0202 (g) (3) Personnel Requirements (V108) and Cross Reference: 10A NCAC 27G .0209 (c) (1) (4) Medication Requirements (V118). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	{V 000}		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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