

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL081-098	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 09/13/2018
NAME OF PROVIDER OR SUPPLIER GRACELAND		STREET ADDRESS, CITY, STATE, ZIP CODE 128 CHANTILLY LANE FOREST CITY, NC 28043		
(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 survey was completed on 9/13/18. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Adults with Intellectual and Developmental Disabilities- Alternative Family Living.</p>	V 000		

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

TITLE

(X6) DATE