

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL011-247	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/25/2018
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NAME OF PROVIDER OR SUPPLIER LINCS	STREET ADDRESS, CITY, STATE, ZIP CODE 6 BYAS LANE/180 BUCKEYE COVE ROAD SWANNANOVA, NC 28778
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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 complaint survey for the Day Activity Services was completed on 9/25/18. The complaint was unsubstantiated (Intake #NC 00142834). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .5400 Day Activity for Adults with Developmental and Intellectual Disabilities. 10A NCAC 27G .5100 Community Respite Services</p>	V 000		

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