PRINTED: 10/08/2018 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED		
			D VAULAGE				
MHL001-092		B. WING		10/0	10/01/2018		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
NORTH MEBANE STREET GROUP HOME 1422 NORTH MEBANE STREET BURLINGTON, NC 27217							
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)	
PREFIX	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATION OF THE APP			COMPLETE DATE	
IAG	TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			DEFICIENCY)			
\/ 000	V 000 INITIAL COMMENTO		V 000				
V 000	00 INITIAL COMMENTS		V 000				
	An annual survey was completed on October 1,						
	2018. No deficiencies were cited.						
							
	This facility is licensed for the following service category: 10A NCAC 27G. 5600C Supervised						
	Living for Adults with Developmental Disabilities.						
	3						

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE