| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | MHL0411161 | A. BUILDING: _____ B. WING _____ | 10/04/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CHANGING LIVES GROUP HOME IV, LLC | 1404 CUSHING STREET GREENSBORO, NC 27405 |

| (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 | INITIAL COMMENTS<br><br>An annual survey was attempted on 10/4/18. According to the facility's Qualified Professional, no clients are currently being served at the facility. No clients have been served at the facility since its initial licensure in March 2018.<br><br>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.<br><br>Observation on 10/4/18 at approximately 12:45 pm revealed:<br>- No vehicles in the driveway<br>- No answer at the door<br><br>Interview on 10/4/18 with the facility's Qualified Professional revealed:<br>- No clients had been served at the facility since its initial licensure on 3/7/18<br>- It has been harder than anticipated to locate the appropriate clientele for the facility and to get the necessary staff in place<br>- He was working with a Local Management Entity/Managed Care Organization in an effort to secure clients.<br>- He would contact the Department of Health Service Regulation upon the admission of their first client. | V 000 | | |