

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL059-063	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/16/2018
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NAME OF PROVIDER OR SUPPLIER POSSIBILITIES	STREET ADDRESS, CITY, STATE, ZIP CODE 81 SOUTH MAIN STREET MARION, NC 28752
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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 was completed on October 16, 2018. The complaint was unsubstantiated (Intake #NC00142734). No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10a NCAC 27g .5100 Community Respite Services and 10a NCAC 27G .5400 - Day Activity</p>	V 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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