STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL018-041	A. BUILDING: _____ B. WING _____	11/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA-FOREST RIDGE	4959 FOREST RIDGE DRIVE HICKORY, NC 28602

(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 A limited follow up survey for the Type B was completed on November 28, 2018. This was a limited follow up survey with 10A NCAC 27G .0209 (c) Medication Requirements (V118), 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366), and 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367) reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0209 (c) Medication Requirements (V118), 10A NCAC 27G .0603 Incident Response Requirements for Category A and B Providers (V366), and 10A NCAC 27G .0604 Incident Reporting Requirements for Category A and B Providers (V367). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.	V 000		