Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL0601359	A. BUILDING: ______ B. WING ______	**11/28/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENNETT HOME	**7136 MCEWEN PLACE** **MINT HILL, NC 28227**

(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 An annual survey was attempted on 11/27/18.. According to the Licensee there are no clients being served at the facility in the past 12 months. The Licensee and Intake worker verified a client is scheduled to move in the next week on approximately 12/3/18. In view of the length of time without a client and the pending admission, a review of the personnel records was completed to assure that personnel was in readiness for the incoming client. No defiencies were found. This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living for Adults with Intellectual and Developmental Disabilities-Alternative Family Living.	V 000		

Division of Health Service Regulation

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