

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL067-059	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 12/12/2018
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NAME OF PROVIDER OR SUPPLIER HILLSIDE COURT	STREET ADDRESS, CITY, STATE, ZIP CODE 108 HILLSIDE COURT JACKSONVILLE, NC 28540
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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>An annual and follow up survey was attempted on 12/12/18. According the Vice President, no clients have been served at the facility since mid-September 2018.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities.</p> <p>During interviews on 12/11/18 and 12/12/18, the Vice President stated clients were evacuated from the facility prior to a hurricane in September, 2018. Due to substantial storm damage to the facility, clients were moved into a sister facility on 9/19/18, and will remain housed there until repairs to the facility are completed.</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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