

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL054-093	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/03/2019
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NAME OF PROVIDER OR SUPPLIER OLD FARM HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1510 FARMGATE ROAD KINSTON, NC 28504
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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 and follow up survey was completed on January 3, 2019. The complaints were unsubstantiated (intake #'s NC00146656 and NC00146686). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p>	V 000		

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