

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL082-079	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/07/2019
NAME OF PROVIDER OR SUPPLIER MERCY CARE II		STREET ADDRESS, CITY, STATE, ZIP CODE 3950 ROSEBORO HIGHWAY CLINTON, NC 28328		
(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 January 7, 2019. According to the Administrative Assistant and Executive Director there are no clients being served at the facility. The last time clients were served at the facility was in May 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>Interview on 01/07/19 the Administrative Assistant stated:</p> <ul style="list-style-type: none"> - The last time clients were served at the facility was in May 2018. - She was aware to notify the Division of Health Service Regulation when clients were admitted to the facility. <p>Interview on 01/07/19 the Executive Director stated:</p> <ul style="list-style-type: none"> - No clients had resided at the facility since approximately May 2018. - She was aware to notify the Division of Health Service Regulations when clients were admitted to the facility. 	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE