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
	MHL020-083	A. BUILDING: ______ B. WING ______	01/10/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OVERLOOK	1669 HENDRIX ROAD MURPHY, NC 28906

(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 1/10/19. According to the Licensee there are no clients being served at the facility. The last time clients were served at the facility was 6/20/18. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Individuals of all Disability Groups. Review on 1/10/19 of Client #1's record revealed: -admission date of 2/16/15 -diagnoses of Mood Disorder, Mild Intellectual Developmental Disability, Anoxia at Birth, Unspecified BiPolar Disorder, and Impulse Control -a Comprehensive Clinical Assessment dated 1/2/14 -the most recent Treatment Plan to include a Crisis Prevention Plan dated 8/16/18 -a discharge date of 6/20/18. Interview on 1/10/19 with the Director of Business Operations revealed: -Client #1 was the last client served in the facility -they were in the process of moving the facility to another location -they would contact DHSR after they were in their new location and were serving clients.	V 000		

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