

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL034-145</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>02/06/2019</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>CLINGMAN</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>4566 SHATTALON DRIVE<br/>WINSTON-SALEM, NC 27106</b> |
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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><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on 2/6/19. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults whose Primary Diagnosis is a Developmental Disability.</p> | V 000         |   |                    |

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