

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL047-153</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>02/28/2019</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>MAJESTIC ALTERNATIVE SUPERVISED LIVING</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>303 CARRIAGE LANE</b> <b>RAEFORD, NC 28376</b>
---	---

(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 and follow-up survey was completed on February 28, 2019. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/Alternative Family Living.</p>	V 000		

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