

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: mhl078-166 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 03/07/2019 |
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| NAME OF PROVIDER OR SUPPLIER RIVERBEND RESIDENTIAL SERVICES | STREET ADDRESS, CITY, STATE, ZIP CODE 4195 SOUTH CREEK ROAD ORRUM, NC 28369 |
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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 |
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| V 000 | <p>INITIAL COMMENTS</p> <p>A annual survey was attempted on March 7, 2018. According to the Qualified Professional there are no clients being served at the facility. The last time clients were served at the facility was September 2018.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G. 1700 Residential Treatment Staff Secure for Children or Adolescents.</p> | V 000 | | |

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