

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-682	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/29/2019
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NAME OF PROVIDER OR SUPPLIER RAY OF HOPE	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 KIDD ROAD RALEIGH, NC 27610
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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>INITIAL COMMENTS</p> <p>An Annual and Complaint survey was completed on January 29, 2019. The complaint was unsubstantiated (intake #NC00143351). No deficiencies were cited.</p> <p>This facility is licensed for the following services: 10A NCAC 27G .1400 Day Treatment 10A NCAC 27G. 1100 Partial Hospitalization</p>	V 000		

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