

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL072-008	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/21/2019
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NAME OF PROVIDER OR SUPPLIER TLC ON THE WATER	STREET ADDRESS, CITY, STATE, ZIP CODE 210 SOUNDWARD LANE HERTFORD, NC 27944
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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>A Limited Follow Up Survey for a Type B was completed February 21, 2019. This was a limited follow up survey, only 10A NCAC 27G.5603 Supervised Living-Operations (V291) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G.5603 Supervised-Living Operations (V291). No deficieincies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600 Supervised Living for Adults with Intellectual Developmental Disabilities.</p>	V 000		

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