

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL081-068</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/06/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MAGNOLIA HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>139 EAST TRADE STREET FOREST CITY, NC 28043</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 and complaint survey was completed on 5/6/19. The complaint was substantiated (Intake #NC00150708). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1200 Psychosocial Rehabilitation for Individuals with Severe and Persistent Mental Illness.</p>	V 000		

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