

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL011-384</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>06/05/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>MARY BENSON HOUSE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>450 MONFORD AVENUE ASHEVILLE, NC 28801</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 survey was completed on 6/5/19. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .4100 Residential Recovery Programs for Individuals with Substance Abuse Disorders and Their Children.</p>	V 000		

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