

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL045-127</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/30/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>EQUINOX RTC</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2420 MIDDLE FORK ROAD</b> <b>HENDERSONVILLE, NC 28792</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>A limited follow up survey for the Type B was completed on 7/30/19. This was a limited follow up survey, only 10A NCAC 27G .0204 Competencies an Supervison of Paraprofessionals (V110) were reviewed for complaince. The following was brought back in compliance: Competencies an Supervison of Paraprofessionals (V110). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents.</p>	V 000		

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