STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL012-068	A. BUILDING: _____ B. WING _____	R 08/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCI - MORGANTON RESPITE CENTER	806 BETHEL ROAD MORGANTON, NC 28680

(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	INITIAL COMMENTS A limited follow up survey for the Type B was completed on 8/14/19. This was a limited follow up survey, only 10A NCAC 27G.0209(c) Medication Requirements (V118) was reviewed for compliance. The following was brought back into compliance: 10A NCAC 27G.0209(c) Medication Requirements (V118). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G.5100 Community Respite Services for Individuals of All Disability Groups.	V 000		