

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL082-079</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>08/29/2019</b>
NAME OF PROVIDER OR SUPPLIER  <b>MERCY CARE II</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3950 ROSEBORO HIGHWAY</b> <b>CLINTON, NC 28328</b>		
(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 follow-up survey was attempted on August 29, 2019. According to the Executive Director there are no clients being served at the facility. The last time clients were served at the facility was from March 20, 2019 thru March 29, 2019.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults with Developmental Disabilities.</p> <p>Observation on 08/29/19 of the facility at 5:00 pm revealed no one was at the facility.</p> <p>Interview on 08/29/19 the Executive Director stated:</p> <ul style="list-style-type: none"> <li>- One client was admitted to the facility on 03/20/19 and discharged on 03/29/19.</li> <li>- There were no clients currently being served at the facility.</li> <li>- She agreed to notify the Division of Health Service Regulation when clients were admitted to the facility.</li> </ul>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE