PRINTED: 09/06/2019 FORM APPROVED

Division of Health Service Regulation

| OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | MHL041-608 | B. WING | | 08/29/2019 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| 2205 BENTON LANE BENTON LANE GREENSBORD, NC, 27455 | | | | |
| | | | | N (X5) |
| (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD | BE COMPLETE |
| V 000 INITIAL COMMENTS | | V 000 | | |
| completed on 8/29/19 #00153978) was unsu were cited. This facility is licensed category: 10A NCAC Living for Adults whose | the complaint (NC substantiated. No deficiencies d for the following service 27G .5600C Supervised se Primary Diagnosis is a | | | |
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| | OVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENTS An annual, follow up a completed on 8/29/19 #00153978) was unsulvere cited. This facility is licensed category: 10A NCAC Living for Adults who | MHL041-608 OVIDER OR SUPPLIER STREET AD 2205 BEN GREENS! SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual, follow up and complaint survey was completed on 8/29/19. The complaint (NC #00153978) was unsubstantiated. No deficiencies | MHL041-608 MHL041-608 B. WING B. WING COVIDER OR SUPPLIER ANE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An annual, follow up and complaint survey was completed on 8/29/19. The complaint (NC #00153978) was unsubstantiated. No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults whose Primary Diagnosis is a | MHL041-608 MHL041-608 B. WING OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2205 BENTON LANE GREENSBORO, NC 27455 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS A. BUILDING: B. WING PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) V 000 INITIAL COMMENTS V 000 An annual, follow up and complaint survey was completed on 8/29/19. The complaint (NC #00153978) was unsubstantiated. No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults whose Primary Diagnosis is a |

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE