

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL083-051	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2019
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NAME OF PROVIDER OR SUPPLIER SHINING STAR CLUBHOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 113 JOHN STREET LAURINBURG, NC 28352
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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>INITIAL COMMENTS</p> <p>A complaint and follow up survey was completed on November 4, 2019. The complaint was substantiated (intake #00156083). No deficiencies were cited.</p> <p>This facility is licensed for the following service 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals With Severe and Persistent Mental Illness.</p>	V 000		

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