STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL095-046	A. BUILDING: _____ B. WING _____	R 11/05/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STEPPING STONE OF BOONE	**643 L GREENWAY ROAD BOONE, NC 28607**

(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 An annual, complaint and follow up survey was completed on 11/5/19. The complaint was unsubstantiated (intake # NC00156220). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .3600 Outpatient Methadone. The client census was 332.	V 000		