

Division of Health Service Regulation

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|--------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>MHL047-153</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>11/07/2019</b> |
|--------------------------------------------------|-----------------------------------------------------------------------------|-----------------------------------------------------------------------|-----------------------------------------------------|

|                                                                                   |                                                                                         |
|-----------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>MAJESTIC ALTERNATIVE SUPERVISED LIVING</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>303 CARRIAGE LANE<br/>RAEFORD, NC 28376</b> |
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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><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed on November 7, 2019. No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .5600F Supervised Living/Alternative Family Living.</p> | V 000         |                                                                                                                 |                    |

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