Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL096-257	A. BUILDING: ______ B. WING ______	R **12/06/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON	**215 DARRELL ROAD** **LA GRANGE, NC 28551**

(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 and follow up survey was attempted on December 6, 2019. According to Accounts Payable staff there are no clients being served at the facility. The last time clients were served at the facility was September 2018. This facility is licensed for the following service category: 10A NCAC 27G .5600C, Supervised Living for Adults with Developmental Disabilities. Observation of the facility on 12/6/19 revealed no answer when surveyor knocked on the front door. All curtains and window blinds were closed. During interview on 12/6/19 the Licensee's Accounts Payable staff stated the Director of Operations hoped to have the facility occupied by the end of the year. Repairs to the facility have been completed and the Licensee was awaiting final inspections. When final inspections were completed the Director of Operations would submit the license renewal.	V 000		

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