

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-012	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/12/2019
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NAME OF PROVIDER OR SUPPLIER HOLY ANGELS, INC-MORROW CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6600 WILKINSON BOULEVARD BELMONT, NC 28012
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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 survey was completed on 12/12/19. The complaint (#NC00157656) was unsubstantiated. No deficiency was cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2200 School year, Before/After School and Summer DD Services, 10A NCAC 27G .2300 Adult Developmental Vocational Programs, 10A NCAC 27G .5400 Day Activity, 10A NCAC 27G .2100 Specialized Community Residential Center, and 10A NCAC 27G .5100 Community Respite Services</p>	V 000		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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