

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL092-958	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/04/2019
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NAME OF PROVIDER OR SUPPLIER DIVINE SUPPORTIVE HOMES	STREET ADDRESS, CITY, STATE, ZIP CODE 3905 MARSH CREEK ROAD RALEIGH, NC 27604
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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 Follow Up Survey for the Type A1 and Type B was completed on October 4, 2019. This was a limited Follow Up Survey, only 10A NCAC 27G.0205 Assessment/Treatment/Habilitation Plan (V112), 10A NCAC 27G.5603 Supervised Living Staff (V290) and NCAC 27G.0203 Training/Supervision of Paraprofessional (V110) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G.0205 Assessment/Treatment/Habilitation Plan (V112), 10A NCAC 27G.5603 Supervised Living Staff (V290) and NCAC 27G.0203 Training/Supervision of Paraprofessional (V110). No deficiencies were cited.</p> <p>This facility is licensed for the following service 10A NCAC 27G. 5600A Supervised Living for Adults with Mental Illness.</p>	V 000		

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