STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL036-239	A. BUILDING: _____ B. WING _____	R 12/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAIRVIEW HOME	1009 FAIRFIELD DRIVE GASTONIA, NC 28054

(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 A limited follow up and complaint survey was completed on December 11, 2019. This was a limited follow up survey, only 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) and 10A NCAC 27G .5602 Staff (V290) cross referenced to 10A NCAC 27G .5601 Scope (V289) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0205 Assessment and Treatment/Habilitation or Service Plan (V112) and 10A NCAC 27G .5602 Staff (V290) cross referenced to 10A NCAC 27G .5601 Scope (V289). The complaint was substantiated (Intake #NC00159026). No deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5600C Supervised Living for Adults Whose Primary Diagnosis is a Developmental Disability.	V 000		