

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL041-941</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>01/02/2020</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>WESCARE ADULT DAY PLACEMENT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2704 NORTH CHURCH STREET GREENSBORO, NC 27405</b>
--	---

(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 and complaint survey was completed on 1/2/20. The complaints were unsubstantiated (intakes # NC00158584 and NC00158809). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .2300 Adult Developmental Vocational Programs.</p>	V 000		

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