

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>MHL097-003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/31/2019</b>
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NAME OF PROVIDER OR SUPPLIER  <b>SYNERGY RECOVERY AT THE BUNDY CENTE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>118 PEACE STREET NORTH WILKESBORO, NC 28659</b>
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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><b>INITIAL COMMENTS</b></p> <p>An annual survey was completed 12/31/19. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories:            10A NCAC 27G .4400 Substance Abuse Intensive Outpatient Program            10A NCAC 27G .5000 Facility Based Crisis Service for Individuals of All Disability Groups</p>	V 000		

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