

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL096-219	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/14/2020
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NAME OF PROVIDER OR SUPPLIER TBI REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 106 US HIGHWAY 117 BYPASS SOUTH GOLDSBORO, NC 27530
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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>An annual survey was completed on January 14, 2020. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .1200 Psychosocial Rehabilitation Facilities for Individuals with Severe and Persistent Mental Illness, and 10A NCAC 27G .5400 Day Activity 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 _____