PRINTED: 01/27/2020 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED
		MHL0601263	B. WING		R <b>01/27/2020</b>
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  2244 VIII LACE LAKE DRIVE					
JASPER'S HOUSE DAY TREATMENT  CHARLOTTE, NC 28212					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
{V 000}	00) INITIAL COMMENTS		{V 000}		
(* 000)	A follow up survey wa 2020. No deficiencie The facility is licensed category: 10A NCAC	as completed on January 27, s were cited.  d for the following service 27G .1400 Day Treatment escents with Emotional or	(V 000)		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE