

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL046-033	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 01/28/2020
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NAME OF PROVIDER OR SUPPLIER CHOANOKE VALLEY	STREET ADDRESS, CITY, STATE, ZIP CODE 1321 WEST FIRST STREET AHOSKIE, NC 27910
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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>A follow up survey was completed 1/28/20. No deficiencies were cited.</p> <p>This facility is licensed for the following service categories: 10A NCAC 27G .2300 Adult Developmental Vocational Program and 10A NCAC 27G .5400 Day Activity.</p>	{V 000}		

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