

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL029062	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2020
--------------------------------------------------	----------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER ARLINGTON HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 216 AGNER LANE LEXINGTON, NC 27292
------------------------------------------------------------	----------------------------------------------------------------------------------------

(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 and Follow-Up Survey was completed on March 2, 2020. No deficiencies were cited.</p> <p>This facility is licensed for the following service category:</p> <p>- 10A NCAC 27G .5600C: Supervised Living for Adults with Developmental Disabilities</p>	V 000		

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